mental health digest

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cover story

Mother and Child

The relationship between a mother and her child is unique among human relationships. This issue of the *Digest* contains several condensations of articles concerned with this relationship and how it develops, as well as other articles on children's mental health.

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mental health digest

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Human Maternal Behavior at the First Contact With Her Young

MARSHALL H. KLAUS, JOHN H. KENNELL, NANCY PLUMB, AND STEVEN ZUEHLKE

During studies designed to assess the effects of immediate, prolonged separation of the human mother from her premature infant following delivery, we observed an unusual routine. When mothers first touched their young, they began by poking and picking at the infants' extremities with the tips of their fingers. To explore this behavior we made observations of women during their first postnatal contacts with their premature or full-term infants. This report describes studies in nine mothers of premature infants and 12 mothers of normal, full-term infants.

All mothers were well at the time of labor and were delivered vaginally, except for one mother of a premature infant who required a cesarean section. The social and economic status of both groups covered a wide range. At the time of the study, all mothers planned to keep their infants. All infants were free of anomalies at birth. The full-term infants were well at birth. The nine premature infants were normal at 3 days of age, except for mild hyperbilirubinemia, subsiding mild respiratory distress syndrome, and short apenic periods. All premature infants were nursed in incubators.

The two groups of mothers were photographed in different surroundings, and both groups were told they were being photographed. Women and their infants were filmed ½ to 13½ hours after delivery (average, 5.3 hours) with a camera 8 to 10 feet from their beds, in a recovery room on the delivery floor or in a room on the maternity division. The mothers' bed was flat, the infant was undressed, and the top of the infant's head was placed at the level of the shoulder, 6 to 8 inches from its mother. Only the first contact was recorded for the mothers of full-term infants. Mothers of premature infants were first filmed 1 to 3 days after delivery, with the camera placed outside the glass wall of the nursery. A nurse demonstrated how to enter the incubator, staying only to answer questions. The first three contacts of mothers with premature infants were recorded. The second filming occurred an average of 3.3 days and the third 5.1 days after delivery.

The following activities were recorded: movement of the infant, position of the mother's fingertips and palms on the trunk or extremities of the infant, amount of time she was smiling, and amount of time physically supporting or encompassing the infant; and, for mothers of premature infants only, the proximity of their heads to the incubator and the amount of time spent with their hands inside the portholes. Behavior was considered "encompassing" if the mother enclosed either the trunk or head of her infant with her entire hand. We also measured the amount of "en face" (a position in which the mother's face is rotated so that her eyes and those of the infant meet fully in the same vertical plane of rotation).

An orderly and predictable pattern of behavior was observed when each mother of the full-term infants first saw her infant. Commencing hesi-

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tantly with fingertip contact on the extremities, within 4 to 5 minutes she began caressing the trunk with her palm, simultaneously showing progressively heightened excitement, which continued for several minutes. Her activity then often diminished, sometimes to such a degree that she fell asleep with the infant at her side. When behavior in the first and third periods—only 3 minutes apart—is compared, there was a decrease in fingertip contact from 52 to 26 percent, an increase in palm contact from 28 to 62 percent, a decrease in touching the infant's extremities from 38 to 22 percent, and an increase in touching the infant's trunk from 24 to 49 percent. Comparing the same periods, encompassing increased from 12 to 30 percent, while smiling decreased from 45 to 34 percent.

Mothers of premature infants, studied on their first three contacts, exhibited an attenuated sequence of the behavior observed in the mothers of full-term infants. The progression from fingertip to palm contact did not occur over the time span of the first three contacts in mothers of premature infants. Instead, fingertip contact increased in the second and third contacts.

Interest in the eyes of the infants in both groups was measured from the amount of verbalization on the audiotapes and from the amount of time the mothers spent in the "en face" position. An intense interest in waking the infants in an attempt to see their eyes open was verbalized by 73 percent of the mothers. Some mothers voiced a relationship between the condition of the babies and their eyes: "Open your eyes. Oh, come on now, open up your eyes." "If you open your eyes, I will know you are alive." Several mentioned that once the infants looked at them, they felt much closer to them. The mothers of full-term infants showed a remarkable increase in the time spent in the "en face" position in only 4 to 5 minutes.

No differences were observed when multiparous and primiparous or married and unmarried mothers were compared.

Our results reveal species-specific behavior in mothers at the time of the first contact with their full-term infants. Although each full-term mother's experiences, plans, and expectations differed, and the period of time between delivery and filming varied, the observed sequences and patterns of behavior were strikingly similar.

There are many possible reasons for the differences between mothers of full-term and premature infants. The small, fragile infant, who may appear so small that he may not live, the late contact with little or no caretaking, the lack of experience with an incubator, and the strangeness of the premature nursery may be barriers to the swift and orderly progression of behavior seen in the mothers of full-term infants. Though the two groups cannot be compared, it is tempting to suggest that the behavior of the mother of a premature infant is arrested at a stage that is normally quickly passed in the mother of the full-term infant.

A comparison of immediate postnatal behavior with that observed in many nonhuman species suggests that this period may be sensitive for the development of close affectional ties in the human mother as well as the goat and sheep. Does separation during this period in the human result in aberrant behavior when the mother and infant are reunited? Because this period appears to be so critical, social and hospital practices which now separate the mother from her sick or premature infant for prolonged periods require a thorough reevaluation.

Neonatal Separation: The Maternal Side of Interactional Deprivation

Clifford R. Barnett, P. Herbert Leiderman, Rose Grobstein, and Marshall Klaus

From the earliest and sometimes apocryphal reports of "wolf children" to contemporary studies of "maternal deprivation," the effects of long-term maternal separation have been described in terms of its detrimental effects on the infant's motor, mental, and affective development. While there has been a theoretical recognition that separation involves both the mother and the infant, little attention has been paid to its effects on the mother.

This one-sided focus on the infant is particularly unfortunate in the light of the many mammalian studies of maternal behavior which emphasize the importance of the young in stimulating maternal behavior. These studies suggest that the timing and duration of the animal mother's earliest contact with her young are crucial in determining her later behavior toward her infant. If contact with her young is delayed by separating the animal mother from her infant for a period of time immediately or shortly after birth, she may exhibit maladaptive maternal behavior when contact is permitted.

There are no comparable data, however, regarding what might be the most "sensitive time" for the *human* mother to undergo separation from her infant. Considering the cultural expectancies built up in the human mother, and the physiological changes she has undergone in preparation for establishing a relationship with her infant, it is reasonable to hypothesize that the immediate postpartum period may be a time of maximum sensitivity for the mother. Separation from her infant in the neonatal period may not permit the mother to develop an attachment to her infant at the time when she is most sensitized to be responsive to him.

The sensory modalities involved in the interaction between mother and infant throw some light on the mechanisms of maternal attachment with which separation interferes. Recent research has shown, for example, that rhesus mothers who were allowed to see or hear their infants, but not to touch them, rapidly decreased the time spent viewing their infants after two weeks of tactile deprivation. The visual eye-to-eye contact between mother and infant which has been suggested is important for the development of infant-mother attachment is greatly impeded for the mother of a premature who must view her infant from afar.

The third component of mother-infant interaction is the caretaking element of the mother's interaction with her infant. Researchers who have studied mothers in the Israeli kibbutz system, where full care is provided for the infants by trained personnel, report that kibbutzim mothers have demanded that they be permitted greater involvement in the care of their infants.

Levels of Interactional Deprivation

Manipulation of the timing and duration of contact, the sensory modalities of contact and the caretaking responsibilities of the mother produce different levels of interactional depri-

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vation. The mother of a full-term infant who gives birth in a hospital, for example, experiences moderate interactional deprivation. She may have some contact with her infant involving all sensory modalities when he is placed on her abdomen in the delivery room and when he is brought to her for a short time during the day. She will not be permitted, however, to spend long intervals with him, nor will she be allowed to feed him for the first 24 hours.

The mother of a premature infant is subject to a much longer period of deprivation. On the day of birth she is completely deprived of contact with her infant. Late in the first postpartum day, she may be wheeled to the nursery only to view her infant in the incubator from behind protective panes of glass. She is subject to this type of severe deprivation until about the 3rd to 12th week postpartum when the infant reaches 2100 grams and is taken out of the incubator and placed in the discharge nursery. The mother may then be allowed to hold her infant for the first time and will be taught how to feed and bathe him. This situation, which produces partial deprivation, is not relieved until the infant is sent home with his mother, usually a week after he has been placed in the discharge nursery.

If the mother of a premature infant were allowed into the nursery on postpartum day 3 to touch her infant while he was in an incubator, she would be subject to moderate rather than severe deprivation. She might not assume any caretaking duties but could have tactile and some aural contact with her infant. By postpartum day 7, the infant may be off gavage feeding and the mother may then, under the nurse's supervision, bottle-feed the infant and change his diapers. For the 3 to 12 weeks the infant is in the incubator, this mother would then experience a form of partial deprivation, rather than the severe deprivation to which mothers are subject under the more usual pattern of care.

We hypothesize that the mother of a premature infant who is deprived of tactile and caretaking contact with her infant in the postpartum period will be less responsive to the infant than the mother who is allowed to handle her infant in the incubator. The mother who is not attached to her infant because of her separation from him shortly after birth may, in turn, deprive her infant of adequate stimulation when she becomes largely responsible for his care.

In order to determine the feasibility of testing these hypotheses with an experimental design, we modified the care procedures of the Stanford Premature Infant Research Center Nursery to permit some mothers to have tactile contact with their premature infants shortly after birth. These mothers were permitted to handle and to care for their infants while they were in incubators.

Over a 2-year period, 41 mothers were allowed first to handle and later to feed their infants. Of this group, 13 mothers were randomly selected for observation and interview during the time their infants were in the unit and after discharge. A comparison group of 16 mothers, who were not allowed to enter the nursery, were followed in similar fashion.

Mothers were told they could come in any time of the day or night to handle their infants. Before being allowed to enter the nursery, they were instructed by nurses in handwashing procedures and they were masked and gowned. The nurses accompanied the mothers and stood by while they put their hands through the portholes of the incubator. Once the infant could be fed easily and successfully, the

mother was permitted to feed him. After the initial period of instruction, the mother was left alone with her infant with the nurse on call to answer questions or help if the need arose.

Infection

Weekly surveillance cultures continued during the entire time mothers were permitted in the nursery. From these data, it would appear that the presence of mothers in the nursery did not increase the risk or the occurrence of infection. A chart review showed no occurrence of staphylococcal, hemolytic streptococcal, or upper respiratory viral disease in the infants during the time when mothers went into the nursery.

Reactions

The initial reaction of the nurses, which varied from mild skepticism to guarded enthusiasm, rapidly shifted to one of whole-hearted enthusiasm. They readily included the mothers in the caretaking procedures. The reaction of the house staff was more mixed. The high turnover rate of the resident staff due to the rotation system did not permit sufficient time for them to adjust to the presence of mothers in the unit. The continuing medical staff of faculty and visiting pediatricians, however, was enthusiastic.

The cases accumulated have suggested three major areas in which separation may produce differences in the mothers: (1) in commitment or attachment to her infant; (2) in the development of a sense of confidence in her ability to take care of her infant; and (3) in her ability to establish an efficient caretaking regimen.

All but two of the 13 mothers we observed who were invited into the nursery reacted positively to the opportunity to handle their infants in the incubators. In the two cases which refused our invitation to enter the nursery, parental concern focused upon the initially poor prognosis given them for their infants. They delayed a month in naming the babies and went through a period of mourning in anticipation of the death of the infants which lasted well beyond the time the infants were declared to be out of danger.

These responses made it clear to us that no single approach to maternal care of the premature will be appropriate for all mothers. There is little systematic data available to determine whether it is psychologically better for a mother to grieve over a "baby" that exists in her fantasy, or over one with which she has had some interaction and to which she has developed some real attachment. A study design incorporating variations in the mother-infant contact for premature and other high risk infants should supply answers to this question.

In a small number of cases the premature mothers who were deprived of, or refused interaction with, their infants tended to resume responsibilities and interests they had prior to giving birth during the 3 to 12 weeks of separation from their newborn infants. When the infant was taken home he appeared to enter the family as an individual and had to compete for the mother's time and attention. The pilot study thus raised the question of whether a mother who has been deprived of interaction with her newborn infant will provide the same type and amount of stimulation to the infant at home as will a mother who has not undergone severe interactional deprivation. This question is now being studied experimentally by monitoring the growth and development of the infant, pre- and post-discharge, as well as the interaction of the mother with her infant at home.

The Mourning Response of Parents to the Death of a Newborn Infant

JOHN H. KENNELL, HOWARD SLYTER, AND MARSHALL H. KLAUS

There are more deaths in the first days of life than at any time in childhood, and almost all occur in a hospital. During the period when an infant's condition is critical, at the time of death and afterward, the staff of a hospital takes actions that are presumably for the benefit of the mother. These actions are based primarily on the staff's personal reactions as well as on common assumptions and customs.

For decades mothers have been separated from their infants in most American hospitals. When the infant is ill or premature, separation is usually complete. Many physicians have believed that a mother should not have contact with her ill or premature infant because of the risk of infection and for fear of severe emotional reaction in case of death. Today, with improved aseptic techniques and the risk of infection no longer a great deterrent, a few centers are allowing mothers early contact with their premature infants. This innovation, which may be desirable when the baby lives, raises an important question. Is it emotionally wise to allow the mother early contact if the baby may die?

The objectives of this study were: to determine whether early tactile contact between mother and infant leads to unduly upsetting reactions after a baby's death; to investigate the importance of factors, particularly tactile contact, in the establishment of an affectional bond between mother and infant; to observe the reactions of parents to the loss of a newborn infant. We anticipated that the strength of the attachment that a mother had formed to her baby could be measured by determination of the length and intensity of her mourning after his death.

The population consisted of mothers whose infants had died in a premature nursery between January 1968 and January 1969. As part of a study of maternal separation there were alternating 3-month periods in which mothers were permitted to enter our premature nursery to have physical contact with their infants or restricted to visual contact through the glass walls. The babies were live-born, with no physical anomalies, and were, for the most part, small premature infants who lived from 1 hour to 12 days. Three infants who died had surviving twin siblings. The mothers came from a wide socioeconomic background and had at least one living child.

Tape-recorded interviews were conducted 3 to 22 weeks after the loss of the baby. They were designed to cover three periods; the prenatal experiences—extent of planning for the baby, mother's feelings about the pregnancy and changes with time; the postnatal experience, with the mother's expectations of the infant's survival, and the mother's contacts with him; and the mother's experience after the baby's death. The mothers were asked about what had happened to them and how they had felt in the days since the loss. After this, the autopsy findings were discussed, and at the end of the interview, a ques-

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tionnaire covering the same topics was given to 13 of the mothers.

Each mother was evaluated on six signs, which, when taken together, we have considered some measure of mourning: sadness, loss of appetite, inability to sleep, increased irritability, preoccupation with the lost infant, and inability to return to normal activities. Every mother was rated on these variables on a scale from 0 to 4.

We determined the "mourning score" by adding the score received on the six variables and averaging the scores of two raters. If three or more of these signs were reported, mourning was considered to be present. The mothers' self-ratings were the same or within one point of the interview evaluations 85 percent of the time.

The scores could not be completed for two mothers. The mourning scores of the remaining 18 mothers were divided into a high (Group H) and a low mourning group (Group L) depending on the side of the median score on which they fell.

All mothers reported sadness and preoccupation with thoughts of the dead baby; all but two experienced insomnia and a disturbance of daily life. Increased irritability was prominent for 15 mothers, and 12 had a loss of appetite. Every mother had problems in at least three of the six items, and 15 of the 18 had problems in five or all six.

High mourning was associated with the previous loss of a baby, either through miscarriage or through death of a live-born infant. Within Group H there had been nine previous miscarriages and four deaths of living children. Within Group L, there was one miscarriage. The mother with the highest mourning score related her intense sadness to her inability to produce a live normal child.

High mourning was associated with positive feelings about the pregnancy. All Group H mothers said that they were pleased with the pregnancy. Within Group L, four mothers were not happy to be pregnant at the time of delivery.

High mourning was suggestively associated with touching the infant before his death. Five of the Group H mothers, and only one of the nine Group L mothers had touched their infants.

High mourning was suggestively associated with a failure of communication between the mother and her husband, or in the absence of a husband, her own mother. Seven Group L mothers had talked with their husbands about their reactions to the loss. Only three Group H mothers had been able to do so. There was no apparent relation between the mourning score and the length of the baby's life, a mother's expectations of her baby's chances to live and her mourning score, or mourning and the number of living children in the household. (It is possible that the results would be different with mothers who have no living child.) All mothers with surviving twins had low mourning scores.

There were no unduly upsetting reactions at the time of physical contact or later pathologic grieving in mothers who did not have a history of hospitalization for psychiatric disease. Pathologic grieving was present in one mother; a postpartum depressive psychosis developed after the death of her infant, whom she had touched. This woman had a history of psychiatric hospitalizations, including a postpartum psychosis after the death of a previous infant whom she had *not* touched.

Eight of the 20 mothers were accompanied by their husbands. Two husbands denied outright that they had ever grieved. They thought that because their wives were upset, they

could not afford to be. Both appeared tense and under considerable strain. Several grieved as long as or longer than their wives, particularly if the baby had been born in another hospital and the husband had been involved in its transportation to University Hospitals. While the baby was in the nursery the father was closer to him than his wife, who was in a hospital several miles away.

The parents were not well prepared for their own mourning responses. Their reaction worried and perplexed them, and in some families this tended to disturb the husband-wife relationship. In several interviews a husband and wife were discussing the loss for the first time.

There were a number of comments related to the mother's stay in the hospital. Mothers found association with other mothers of live healthy babies extremely difficult. When babies were brought to their mothers at feeding time, the feelings of sadness were accentuated. The mothers could deal with questions from other mothers who did not know that the baby was ill or dead, but were disturbed when nurses or aides would offer to bring "your baby for his feeding." These lapses of communication and lack of awareness of the mothers' situation among staff personnel angered the mothers. Lapses of communication among the nursing and medical staff were reported which emphasized the importance of interstaff communication and consistency in reports given to parents.

The mourning scores indicate that mourning was present in the mother of each infant who died—whether the infant lived for 1 hour or for 12 days, whether the infant was 3000 grams or a nonviable 580 grams, whether or not the infant was planned and whether or not the mother had touched the baby. The presence of mourning in all mothers implies that a substantial degree of affectional bonding *precedes* tactile contact between mother and infant.

The first objective in this study was to determine whether it was psychologically safe for a mother to have tactile contact with a sick infant whose prognosis was uncertain. With the evidence that physical contact does not cause unduly upsetting immediate reactions or appear to result in pathologic mourning, it will be reasonable to proceed with investigations of the effects of this contact when the baby lives. Since it is so difficult to identify the babies who will die, should we not allow every mother to have physical contact with her baby if she wishes?

At present when an infant dies in the hospital all evidence of his existence is often removed with amazing rapidity, and no arrangements are made for the parents. The requirements for efficiency and for the mental comfort of the modern hospital society may have crowded out requirements for the individual.

As a result of this study we have instituted the changes in room assignments and communication suggested by the parents. We have made changes in our approach to newly bereaved parents. At the time of the baby's death we tell the parents about the usual reactions to the loss of a child and the length of time that they will last. We indicate that it will be beneficial if the parents talk with each other about their feelings. A day or two after the death we meet with the parents to go over the same suggestions. Husbands particularly need this advice. The parents are interviewed 3–4 months after the death. These discussions with both parents together appear to be valuable; they are especially important when there has been a previous loss.

The Birth of an Exceptional Child

EUGENIA H. WAECHTER

During pregnancy every woman wishes for a perfect child and fears the birth of an abnormal one. When the baby deviates drastically from the anticipated child, the occurrence of the loss of the idealized child and the demand to accept a deviant child can be overwhelming.

Parents need to grieve for their lost perfect child before they can form an attachment to the imperfect one. The process involves anger, which can be directed toward anyone. Mourning impairs the capacity to recognize, evaluate, and adapt to reality. Whenever possible, plans for the baby should be delayed until the mother can participate, otherwise mourning and depression may persist.

Anxiety is a dominant reaction. The question, "What caused this?" is charged with feelings of biological inadequacy. The parents may be asking, "What's the matter with us as progenitors of children?" The mother's failure to produce what she has so long prepared herself to create may be a threat to her sense of adequacy and worth and to her femininity. These feelings may be heightened by the reserve the parents encounter from their families and professional people.

The culture in which the parents live influences the kind and intensity of their feelings. Our culture sets rigid standards in regard to appearance and intellectual functioning. Perfectly formed, beautiful children represent the ideal; any visible physical defect or intellectual impairment has significance as a basis for class and caste distinctions. Since one of the greatest threats is loss of standing in the community, the anxiety about the child's birth is related to the parents' ego status.

Then, deformities and abnormalities are identified with grave disqualifications. There still lurks the verdict that congenital conditions have a sinful basis, so that the parents may feel that the child's condition is retributive. Parents may search themselves for past misdeeds and may attribute the defect to some act or occurrence in their lives. If the pregnancy was originally unwanted, the feelings of punishment may be pronounced.

The experiences which parents have had with people close to them and in their environment influence the significance of an exceptional child. If their childhood was satisfying, they have learned to tolerate degrees of frustration and have developed strength to bring to this situation.

Experiences which the parents have had with other handicapped children and adults may also affect their degree of concern. In all human beings there are the vestiges of unwholesome attitudes and feelings toward people who are physically or mentally different. If in their childhood the parents knew a "different" child, they may remember the hostility directed toward him by siblings and peers and the conscious or unconscious taboo and rejection which he had to bear. If they responded to this with guilt, pity, repugnancy, or overprotectiveness, these feelings may become reactivated.

Professional Intervention

The outcome is profoundly affected by the manner in which professional personnel, particularly nurses, work with the parents during the period

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immediately following the birth of an exceptional child. In times of crisis, people are more sensitive and vulnerable to the reactions of others. The parents may assign great meaning to what nurses or others do throughout this period. They will watch the facial expressions of nurses and other personnel for signs of revulsion and withdrawal.

This situation is a challenge to those working with parents. The birth of an exceptional child affects them also, for they too are products of their culture and are influenced by previous experiences and knowledge of what the experience means to the parents. Nurses and others may feel helpless, anxious, and angry. They may feel threatened and uncomfortable and not know what to say with the result that the parents think that they are matter-of-fact, uninterested, casual, and detached. Often nurses retreat, leaving the parents to bear their anxiety alone.

The feelings which personnel have about an exceptional child may result in their "hiding" the baby in the hospital. Such an action communicates to the parents that their baby is not acceptable to others and adds to their feeling of having done something of which to be ashamed.

These reactions point to the need for personnel to examine their own values. In addition, they must possess the attitudes and skills necessary for helping the parents to use the resources available within themselves and the community to meet the problems which confront them.

This help should be forthcoming as soon as the baby is born. One of the first things mothers want to know is the condition of their babies. If they are made to wait or are met with evasion, much energy is consumed which will be needed later when the diagnosis is made known. Nurses should be available to parents at the time when the diagnosis of an abnormality is communicated. If they can understand that the anger directed at them is not personal and if they can stay near the parents, support them, and bear their mourning, they will be making a tremendous contribution.

The mother cannot invest any feeling in the exceptional child until she can feel and talk about her disappointment. The process of grief must be facilitated through repetitious discussions. Interpretations of the child's condition must be synchronized with this mourning process.

Nurses and other personnel should encourage parents to react as fully as they desire in an atmosphere of acceptance. This task can be difficult, since our culture frowns on expressions of deep feeling. It is much easier for mothers to accept their own feelings if they are accepted by people around them. A mother will feel understood if the nurse helps her to know that her feelings are natural. An attitude of warmth and acceptance of parents which is communicated by deeds rather than words help parents to regain self-esteem.

The parents may withdraw to escape facing the reality of such a situation. At times they want silence and solitude. Nurses and others must avoid labeling this behavior as "rejection of the child," for in the face of criticism of this kind the parents' anger may be directed toward the child so that they do not wish to see him. Withdrawal may also stem from a feeling of inadequacy for coping with such a tremendous problem. Nurses can be of assistance if they can respond to withdrawal with understanding and bountiful giving. It can help to relieve the mother's guilt about her lack of motherliness if she can be helped to understand that such feelings develop

gradually as a mother cares for her child.

If the mother indicates an initial overprotectiveness toward her child, this behavior must be respected, for it is a defense which the mother needs against anxiety and disorganization. Pity for herself may become displaced as pity for her child. If the nurse is critical, the defense will only be deepened.

Professional personnel must be careful to avoid over-optimistic statements regarding the future. Reassurance only serves to relieve tension within the nurse; it does not help the parents to begin to test objective reality. Likewise, lapsing into professional terminology adds to the confusion and helpless feelings of parents when they need to understand and to be understood.

To facilitate the mourning process, the mother needs physical rest. Regression is natural and dependency longings are increased. By accepting the mother's increased need for personal care, the nurse demonstrates that she can care for a person who has given birth to a child who deviates from normality. The nurse can help the mother by taking meticulous care of the baby with interest and concern, exhibiting to the mother a realistic investment in the deviant child and helping her to work through her concern about her own inadequacy. Since the baby is still an extension of the mother, when the nurse shows interest in the baby by giving it careful physical care, she assists the mother to feel comfortable with herself.

The nurse can help the mother when she shows signs of wanting to care for her baby. The feeding experience holds great significance. When the mother can feed her baby and sense some response in the infant, she will begin to satisfy her need to be a good mother and her self-esteem will be heightened. It must be remembered that with each feeding the mother must face her infant's deviance, with the result that her feelings of anxiety, frustration, and guilt are reactivated. If the mother refuses to feed her baby, the nurse should avoid pushing her too quickly.

When the mother shows that she is ready to learn how to care for her baby, sympathetic, patient, and understanding help will heighten her feelings of adequacy and influence the mothering which she will be able to give later. Learning to do something specific enables a mother to channel some of her dependent feelings into the feeding experience with her baby.

The nurse must observe the infant and learn his responses as an individual. She can help the mother to learn the infant's signals of hunger and the method of feeding which is most satisfying for both of them. The nurse should stand by to lend support and assistance as necessary, but avoid being overly directing.

After the immediate shock of the birth of a child who deviates from normality, the parents begin to reflect on the problems facing them and those they must meet in the future. In most cases, one parent is concerned about imparting information about the child's deviance from normality to the other parent. This will be especially evident if one parent feels responsible because of a family history of congenital defects or for other reasons. The concern will be manifested regardless of whether the marriage is happy or unstable.

The mother's dependency needs, which were heightened during pregnancy, continue to be great during the postpartum period. Her orientation is still narcissistic. If she feared what the baby would do to her relationship with her husband, this fear will be intensified when her baby is

born with an abnormality. When the husband is not aware of his wife's needs, but is withdrawn into his own grief, the mother's anxiety may become acute.

The arrival of a child who deviates from normality makes great demands on the father. Often his responsibilities are so overwhelming that it is difficult or impossible for him to provide the love which his wife needs. Unless he receives assistance, the parents' relationship may be endangered.

Concerns About Other Children

The structure of the family and the ages of other children influence the parents' feelings. Children need an explanation of a sibling who is different. If they do not receive such an explanation from their parents, they come to conclusions drawn from their own limited experience.

The reactions of the older children influence the feelings of the parents. Some acceptance on the part of older children may relieve the parents' concern. Parents fear their children's questions and condemnation, for they have not had the time or the help they need to become free of guilt, shame, and remorse. Some parents fear that their children will spread the news of the problem before they can mobilize themselves to cope with the curiosity and feelings of their relatives, friends, and community. Occasionally concern is heightened by the sibling's rejection of the baby. It is difficult for some parents to see that an older child normally has feelings of sibling rivalry, and they may attribute the rejection to the deviance.

Many mothers fear that their love and energy will be insufficient to meet the demands for mothering all their offspring. The mother who feels compelled to dedicate herself to her exceptional child as a means of resolving her problem not only may fear that she will deprive her older children, but may sense the threat of losing shared, close living experiences.

By assisting the parents to resolve feelings of inadequacy and by reinforcing their self-esteem, professional personnel can help them to face their children's questions.

Reactions of Relatives and Friends

The threat of losing friendships may heighten the parents' anxiety, since they may feel a need for the support of friends and relatives during this crisis. Close friends and relatives will react in different ways. They may feel reticent because they fear that they are unable to cope with their feelings. They may fear that they will communicate pity. If they are within the child-bearing years, they may be frightened that the abnormal condition will appear in one of their children. Relatives may feel that the "stigma" is a reflection on themselves. Many parents encounter embarrassment or curiosity on the part of acquaintances and neighbors. Some parents feel resentment and anger at these reactions and, unless they have help, may jeopardize important relationships at a time when they need them. By helping parents to resolve feelings of shame, guilt, and inadequacy, the nurse can also assist them in maintaining their important relationships.

A nurse who is aware of her own feelings and values, who is cognizant of the meaning of such an experience, who has the strength and empathy to give of herself during this acutely stressful situation, has a tremendous opportunity to contribute to the comfort and unity of the family, and to help create an optimal developmental environment for the child.

The Shaping of Mother's Behavior by Children

Joy D. Osofsky

The basic model of socialization, the action of a parent upon a child, may be too limited to take into account data which have appeared in socialization work, suggesting important influences of children upon parents' behavior. Using a method which structured parent and child behaviors and an intervention approach, we investigated some of the possible child effects upon parents.

The subjects were 65 white middle-class mothers. Each woman had at least one female child between the ages of 8 and 14. When a mother came to the laboratory, she was instructed to have a child, who would soon arrive, perform some specific tasks. These included putting together puzzles, making designs, and telling stories. It was emphasized that there was no correct way to deal with the child, but that the experimenter was interested in her individual approach. She was then instructed in how to put the puzzles together, tell the stories, and make the block designs. She was also told that she would have about 15 minutes to complete the tasks, that she would be observed from behind a one-way mirror, and that the session would be video taped. Each mother was then joined in the room by a female child, who was not her own. Four role-playing girls were used ranging in age from 10 to 12. Role players were randomly assigned to mothers. The experimenter had trained the role players to create standardized patterns of child behavior for each of the three tasks. The role players were trained to react in a standard fashion to all mothers.

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The mothers were presented with the child's behavior in three tasks in counterbalanced order. The three tasks were Object Assembly, Picture Arrangement, and Block Design. During the Object Assembly task, the child acted dependent and asked the mother to help her with the puzzles. During the Picture Arrangement task, the child acted independent and insisted she could tell the stories herself without the mother's help. When presented with the Block Design task, the child acted stubborn, refusing to participate and continue the task to completion.

Mothers' behavior was rated from the video tapes. Ratings were made on specific behaviors observed in each situation and were then combined to form scores on six dimensions:

1. Reflective teaching method—a measure of the degree to which the mother seeks out and utilizes information from the child;
2. Reflective-directive (moderate) teaching method—a combination of reflective behaviors and directive behaviors;
3. Directive teaching method—the degree to which the mother tells and shows the child what to do;
4. Warmth—the amount of interest and involvement shown in the child's behavior and performance;
5. Reinforcing independent behavior—the degree to which the mother encourages the child to do the tasks by herself;
6. Reinforcing dependent behavior—the degree to which the mother encourages the child to follow the mother's lead.

A posttask interview was given to assess whether or not the subjects per-

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ceived the differences in the child's behavior, and to evaluate the degree of similarity of the situations to experiences which they had with their own children.

Maternal behavior was found to differ on the six dimensions in the three situations. The behavioral dimension measuring warmth occurred consistently in all three situations; however, other dimensions appeared more selectively. Mothers were moderate in teaching method in the dependent and independent situations, and reflective in the stubborn situation. Although all types of reinforcing behaviors were possible in each situation, mothers selectively reinforced independent behavior in the task calling for independent behavior, dependent behavior in the situation requiring stubborn child behaviors, and neither independent nor dependent behaviors in the task calling for dependent child behaviors.

By controlling the behavior of the child it is possible to define the stimulus characteristics, to observe differences in parental responses in interaction situations, and to draw inferences about the effects of children upon parents. For example, although mothers could have reinforced dependent or independent behaviors when the child played any of the three roles, mothers reinforced independent behavior only when the child was in the independent role. This finding would be consistent with a hypothesis about socialization suggesting that the parental response to children's independent behavior is frequently reinforcement. However, stubbornness may influence mothers to desire more compliance in the form of dependent behaviors. This would be consistent with the mothers' reinforcing of dependent behaviors when the child acted stubborn, but not when the child acted independent, in the present investigation.

The consistency found on the warmth dimension suggests that warm responses occur frequently as part of a mother's behavioral repertoire. However, the number of cold responses may have been reduced and the number of warm responses increased by observing mothers with children who were not their own in a laboratory situation; the mothers may have felt pressure to behave in a socially desirable manner.

The posttask interview revealed that parents often play games with their children similar to those used in the laboratory. In addition, the mothers reported that their children often act dependent, independent, and stubborn in a similar fashion to the role players. The interview suggests that the design and findings of the study may reflect a somewhat realistic situation.

The behavior of the mothers in the laboratory situation corroborated a fact cited consistently by parents; that is, that their behavior differs depending upon their child's personal characteristics and behavior. Subsequent studies are needed further to define parameters of child effects upon parental behavior and to elucidate any similarities and differences in parental responses to their own and other children's behavior which may occur in naturalistic and in structured laboratory situations.

Child-Care Attitudes and Emotional Disturbance Among Mothers of Young Children

Bertram J. Cohler, Justin L. Weiss, and Henry U. Grunebaum

The relationship between the mother's personality and the psychological development and adjustment of her child has been the object of much study in psychiatry and child development. Less study has been devoted to the significance of the child-care situation for the mother and to the relationship between her personality and her child-rearing attitudes and behaviors. This study is concerned with the relationship between maternal personality and child-care attitudes and with the factors which are related to hospitalization for severe emotional disturbances during the first years following childbirth.

The Concept of Development Issues

The major assumption is that motherhood may be viewed as a series of developmental tasks, each of which represents, for the mother, a crisis or conflict which must be resolved in an adaptive manner in order for further maturation to take place. Failure to resolve the conflicts associated with child-care issues which all mothers must resolve during the first years of the child's life appears to be associated with maternal breakdown and hospitalization.

The developmental tasks which comprise the period of motherhood are unique in the life cycle, since the effectiveness with which a woman resolves these issues is dependent both upon her own personality and upon the manner in which her child presents her with his own needs. For example, in a woman who manifests difficulty in forming close and reciprocal relationships with others, severe emotional disturbances may result when such a woman finds herself unable to resolve that developmental issue with the baby which concerns the establishment of a reciprocal and sharing relationship.

While the original appearance of a particular issue in the mother-child relationship is dependent primarily upon the child's developmental progress, the degree to which the issue survives and is resolved depends upon the mother's ability to resolve this issue in terms of the child's needs.

We have suggested that there are a number of developmental issues or points of crisis in the early mother-child relationship. The child's own development and his mother's continued maturation are shaped by the extent to which these conflicts are resolved, and by the manner in which they are resolved. Conflicts associated with each developmental task may be resolved to a greater or lesser extent, depending upon the mother's ability to perceive and negotiate an appropriate solution. A mother's feelings or attitudes may be seen as adaptive or maladaptive to the extent that they facilitate or hinder the resolution of a particular issue.

Attitudes Toward Child Care

This concept of adaptiveness is prevalent in many social psychological discussions of attitude formation and change. Attitudes reflect a critical function of the ego, that of appraising and labeling interpersonal transactions.

Attitudes toward child rearing per-

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mit a mother to appraise and interpret transactions involving herself and her child. To the extent that her appraisal and interpretation are incongruent with the needs or intentions of the child, her attitudes are maladaptive for the resolution of the issues which are salient at that time.

Resolution of each of the several developmental tasks of child rearing depends both upon the mother's adjustment and the nature of the social milieu. Cross-cultural data suggest that situational parameters may be of great importance in understanding the manner in which mothers confront child-care issues. Mothers in our culture are believed to have greater ability to mold their child's personality than is true of mothers in other cultures. This emphasis on the mother's role in molding her child's personality is due, in large part, to the isolation of the nuclear family from the larger kinship system. Parents assume that any difficulties the child may display, such as bad temper, must be due to their poor upbringing. Since the mother is the major socialization agent, such character flaws can be traced back to the mother's influence on her child. Thus, each step of the child-rearing process is laden with anxiety and each aspect of child care is viewed as of critical importance for the child's subsequent development. Considerable guilt is induced in the mother who is held responsible, by herself and by others, for all aspects of the child's personality development. For this reason, it is not surprising to find that mothers in our own culture appear to feel more hostility to their own children and to evidence greater emotional instability than is true of mothers in most other cultures.

Such cross-cultural data provide a baseline for comparing the degree to which mothers in our culture resolve this feeling of guilt. Since mothers typically express considerable ambivalence regarding the caretaking role, this ambivalence must be recognized and expressed if a woman is to deal in a realistic manner with the child-care process. A woman must also be able to resolve such issues as the distribution of role responsibilities between herself and her husband.

Postpartum Emotional Disturbances

Clinical and cross-cultural data suggest that a woman's attitude toward the child-care process must play a role in the manner and the degree to which she is able to resolve the developmental task associated with motherhood. Nowhere is this problem likely to be greater than among woman who have suffered severe emotional disturbances during the first years following childbirth and especially among those who require hospitalization. The fact of a woman's admission to a psychiatric hospital may be regarded, in part, as an index of her inability to deal effectively with the developmental tasks posed by child care. Such women are frequently diagnosed as suffering from a "postpartum" illness, in spite of the fact that this is not a recognized term in psychiatric nomenclature.

Nor is there any clear agreement regarding the duration of this so-called postpartum period. The term may apply to any period from the first few days following childbirth, to a year or more, to any time following delivery.

Without dismissing the possible significance of physiological determinants, it seems clear that better understanding of the development of severe emotional disturbances subsequent to childbirth depends heavily upon explication of psychological factors.

This so-called postpartum syndrome represents a good test of the hypothesis that maladaptive attitudes regard-

ing particular aspects of the child's care would be related to the mother's inability to resolve these issues and her subsequent hospitalization. Mothers in our culture are held responsible for the development of the child's personality to a greater extent than in many other cultures, leading to the more frequent expression by mothers in our own culture of their inadequacies in caring for their children. Such an ability to admit to one's own doubts and concerns would seem to provide greater flexibility and promote a more ready adaptation to conflicts in child care than might obtain among women who felt that they must deny such concerns. For this reason, it was expected that hospitalized mothers would be less able to admit to their ambivalent feelings regarding child care and the maternal role than nonhospitalized mothers and that they would adopt a highly conventional approach in responding.

The Maternal Attitude Scale

For the assessment of maternal attitudes a Maternal Attitude Scale was constructed and a factor analysis carried out.

The first factor concerns the resolution of the child's expression of sexual and, especially, aggressive impulses and suggests that this factor should be labeled inappropriate vs. appropriate control of the child's aggressive impulses. Mothers achieving a high positive score on this factor (a high score indicated maladaptive attitudes) indicate overly permissive or, more frequently, overly rigid and restrictive attitudes regarding the control of the toddler's impulses, particularly those of aggression. We have assumed that toddlers manifest negativistic, destructive, and challenging behaviors and that the issue which this presents for the mother is the manner and degree to which she feels she can modulate the child's aggressive and destructive behavior by providing appropriate substitutes. For example, rather than punishing a child for breaking a valuable object, it is possible to provide toys which can be taken apart and put back together again. The intent behind the act is preserved, while the behavior is channeled into a more socially appropriate form.

The second factor can be labeled discouragement vs. encouragement of reciprocity. Mothers earning a high positive score on this factor (maladaptive attitudes) believe that infants do not and cannot communicate with their mother. These mothers feel that they cannot understand what an infant wants from others. A mother earning a high score on this factor feels that infants do not mean anything by a smile and that such smiles are little more than accidental grimaces, perhaps resulting from gas pains. They also believe that it is a waste of time to play games with babies, since babies wouldn't realize that their mothers were playing with them.

The third factor can be labeled appropriate vs. inappropriate closeness. Mothers earning a high positive score on this factor score in the direction of adaptive attitudes, while women scoring low indicate maladaptive attitudes. Such women feel that pregnancy and childbirth are depleting and destructive. They feel anxious about the prospect of delivery and are afraid of the possibility of injury. At the same time, they wish to be the baby's sole caretaker, and worry that the baby might develop an attachment to someone other than themselves, and about leaving the baby with a baby-sitter or taking on activities outside the home. Women with maladaptive attitudes on this factor view the baby as a narcissistic extension of the self and seek, through

the baby, to attain for themselves supplies which were lost in the experience of childbirth.

The fourth factor is labeled acceptance vs. denial of emotional complexity in child rearing. Mothers with high positive scores indicate adaptive attitudes and are able to express concerns about how well they function as mothers. They admit that motherhood is sometimes far more work than pleasure and that they sometimes do not know what is best for the child. Nor do they feel that everything that a mother does for a child is done with his best interest in mind. They believe that children should be encouraged to express their negative, as well as their positive feelings and that, since mothers can make mistakes, it is permissible for them to back down if they find that they are wrong after telling a child to do something. Mothers with a high negative score deny any concern regarding the performance of the maternal role. Since there is almost no relationship between this factor and other measures of test-taking defensiveness, we believe that the denial manifested by mothers scoring low represents more than a conscious set to respond to the items in a defensive manner.

The fifth factor is labeled comfort vs. discomfort in perceiving and meeting the baby's needs. Mothers who attain a high positive score believe they can understand what babies want and that they can provide for this support. Mothers with a high positive score believe that breast feeding is better than bottle feeding and that demand feeding is better than scheduled feeding. They believe that they can tell what an infant wants from his cry and that they can understand the baby's physical needs.

Two other indices have also been derived, a measure of the tendency to agree or disagree with the items (overall agreement vs. disagreement style), and a measure of the tendency to respond to these items in the manner in which the subject believes the typical mother responds to them (independence vs. conventionality set).

Procedures of Study

Two groups of subjects were used: A sample of 35 nearly consecutive admissions to the Massachusetts Mental Health Center over an 18-month period, and 35 nonhospitalized women who had never sought psychiatric help.

The sample of hospitalized mothers represents primarily a group of actually disturbed patients. While the average length of hospitalization was fairly brief, there was a range of from 4 to 60 weeks. A majority of the hospitalized mothers had never been hospitalized before. The diagnoses of the 35 patients indicates that 42 percent were diagnosed as psychotic (either a schizophrenic or affective disorder). Among the 58 percent of the patients who were "without psychosis," the largest proportion manifested either a situational (depressive) reaction, a personality trait disorder, or an emotionally unstable personality. Ratings of interviews conducted by the social worker indicated that 57 percent of the mothers had shown changes in their behavior toward their families in the 6 months preceding hospitalization, suggesting that the mother's disturbance was of recent origin.

There was considerable variation in the age of the youngest child at the time of the mother's admission, from as young as 1 month to as old as 36 months. Only 10 of the 35 mothers were primaparae.

The sample of nonhospitalized mothers was recruited via newspaper advertisement. Each patient was matched on an individual basis with a nonpatient mother on the factors

of sex and age of youngest child, and mother's education, social class, and religion (Catholic vs. non-Catholic). All subjects were administered the MMPI. Information was collected from all subjects regarding their educational attainments, husband's occupation, religious preference, and age, as a part of a more extensive family information questionnaire. A brief screening measure of intellectual functioning was obtained with the Shipley-Hartford Retreat scale of intelligence.

Variables Related to Hospitalization

Information regarding the mother's adjustment prior to hospitalization was gathered from the patients' hospital records. The majority of hospitalized mothers indicated a good premorbid social adjustment.

Information regarding the life issue most closely associated with hospitalization was obtained from the patients' therapists. These physicians were asked a number of questions, chief among which was the issue in the patient's life which they believed to be most closely associated with the patient's breakdown and admission to the hospital. Cooperation was voluntary and women were permitted to leave the study if they found the tests to be upsetting. Three hospitalized mothers refused, at the outset, to participate, but no mother dropped out who had begun the testing.

Relationship Between Maternal Attitude Scale and Background Variables

Women with more maladaptive attitudes concerning the appropriate control of the child's angry and aggressive impulses are likely to have less education and to be older. They are also likely to show more impoverished intellectual resources on the Shipley-Hartford scale, and to indicate a greater need for social approval although they are not likely to indicate any greater admission of psychological distress.

Feelings of being unable to achieve a reciprocal relationship with the baby are associated only with greater impairment in abstract functioning on the Shipley scale. Feelings of being able to achieve appropriate closeness with the baby are associated with greater verbal facility on the Shipley scale, with a greater need to view oneself in a positive light, and with a tendency to admit to deviant thoughts and feelings. The acceptance of greater complexity in feelings toward child care is associated with greater verbal facility and with a lessened need for social approval. The fifth factor, comfort vs. discomfort in perceiving and meeting the baby's needs, is not related to any of the background factors.

Comparison of Patient and Nonpatient Mothers

Each patient mother was matched with a nonpatient mother on the basis of several demographic variables.

Predicted differences were obtained for two of the five factors, "failure of reciprocity" and "acceptance of emotional complexity."

In the case of the fifth factor, "comfort in meeting the baby's needs," the hypothesized results did not obtain. The predicted difference did obtain for the response set measure of independent vs. conventional approach to the task. Hospitalized mothers indicated a significantly greater tendency than nonhospitalized mothers to answer items in the "typical" direction and to disagree with the items.

These results suggest an interesting paradox. Mothers in the hospitalized group approached the task with the intent of answering items in the manner of the typical mother, but on three of the five factors their attitudes are

different from those of the nonhospitalized group. Hospitalized mothers deny that the typical mother has concerns regarding child rearing or that she is concerned with establishing a reciprocal mother-child relationship. Hospitalized mothers also tend to believe that mothers do not feel uncomfortable in learning to meet their infant's physical needs, while nonhospitalized mothers admit to greater concern regarding this child-care issue. These findings suggest that the hospitalized mothers do not have a realistic perception of the child-care attitudes of the typical "normal" mother and that they express stereotyped and undifferentiated attitudes concerning these child-care issues.

Relationship Between Child-Rearing Attitudes and Variables Pertaining to Hospitalization

Since mothers require hospitalization at different points during the first few years of the child's life, there may be a variety of tasks associated with this phase of the mothers' own psychosocial development; the mothers' breakdowns may be related to failure to resolve one or more of these tasks. Also a mother's ability to negotiate these developmental tasks is related to her own life adjustment. Since attitudes are regarded as indices of the manner in which an individual schematizes his interpersonal environment, it may be hypothesized that both the mother's premorbid adjustment and the role issue most closely associated with hospitalization will be related to particular issues regarding which less adaptive attitudes are indicated.

This hypothesis is supported both from the premorbid adjustment measure and from the rating of the life issue associated with hospitalization. Mothers who manifest a less adequate premorbid social adjustment are more likely to feel unable to achieve reciprocity between mother and baby and are more likely to feel that the baby represents a narcissistic extension of the self.

There is no one role issue most closely associated with hospitalization. The category conflict with the patient's own family of origin or her husband's family accounts for only 35 percent of the cases. The most striking result is the significant association between the life issue most closely associated with hospitalization and the age of the youngest child at the time of admission. The youngest mean child's age obtains for mothers whose hospitalization is associated with the assumption of the parental role, followed by hospitalization associated with the care of the youngest child, some child other than the youngest, and conflict with parents and in-laws.

The role issue associated with hospitalization is independent of formal diagnosis or premorbid social adjustment.

Significant relationships obtain between the role issue associated with hospitalization and two of the five attitude variables, "Perception of the baby's needs" and 'inappropriate vs. appropriate control" of the child's impulses.

With reference to the attitude factor of "perception of baby's needs," there is a highly significant association between the role issue associated with hospitalization and scores on this factor. This finding is accounted for mainly by differences between the two groups of mothers for whom the role issue associated with hospitalization was either pregnancy and assumption of the parent role or care of the youngest child and the other two groups. It can be concluded that the mothers in both of these groups express maladaptive attitudes regarding their ability to understand the baby's cues of his need states, but the

former group also indicates more maladaptive attitudes regarding those aspects of female sexuality which are associated with pregnancy. This finding assumes particular importance when it is recalled that the role issue judged to be more closely related to the hospitalization of these mothers stems from their feelings about their own femininity, as related to the assumption of the parental role, rather than from specific issues in the care of the baby.

While the mothers of older children do not show more maladaptive attitudes regarding the Maternal Attitude Scale Factor of "perception of the baby's needs," they do indicate less adaptive attitudes regarding the factor of "appropriate control of the child's impulses." Mothers whose hospitalization is associated primarily with either the care of some child other than the youngest or family conflict express less adaptive attitudes regarding this factor than mothers in the other two groups. The former two groups of mothers tend to have older children than the mothers in the latter two groups and express more adaptive attitudes regarding aspects of child care which are more salient with toddlers than with infants.

It is clear that mothers in a mental hospital feel that they are less able than the nonhospitalized mothers to establish a reciprocal relationship with their child. It is not so much, as we had believed, that these women perceive the child as a narcissistic extension of the self or feel unable to meet the child's physical needs. Rather, hospitalized mothers view the child as a separate being, but one who is passive and unable to communicate or achieve reciprocity with his mother.

Not only do these hospitalized mothers feel unable to foster the mother-child mutuality but they are unable to acknowledge the complex and ambivalent feelings expressed by the nonhospitalized mothers. These mothers view the child-rearing process in a highly stereotyped manner and respond more in accordance with what they believe the typical mother feels or should feel about child rearing than in terms of their own feelings.

The fact that hospitalized mothers have such stereotyped and conventional attitudes toward child rearing indicates that these women are less able than nonhospitalized mothers to recognize and deal with these feelings, a factor which may seriously impair their ability to respond appropriately to these child-care issues.

There is evidence concerning the importance of attitudes in achieving adaptation to social reality when we turn to the findings regarding life issues associated with hospitalization. Mothers for whom the role issue leading to hospitalization was judged to be some aspect of pregnancy and assumption of the parent role or some aspect of the care of the youngest child showed more maladaptive attitudes concerning the process of interpreting and meeting the baby's needs. Mothers in these two groups have much younger children than mothers in the other groups, suggesting that child-rearing issues to which the attitudinal factors refer are much more salient issues for these mothers with younger children.

The mothers for whom the role issue leading to hospitalization was some aspect of pregnancy and assumption of the parent role also indicate less adaptive attitudes regarding those aspects of female sexuality pertinent to pregnancy than mothers experiencing conflict regarding the care of their youngest child. On the other hand, mothers whose breakdown was associated with the care of

some child other than the youngest or with role conflict with the family have older children and experience particularly maladaptive and sexual impulses.

Our findings suggest that we must reexamine the concept of the "postpartum" syndrome. There was little evidence that the risk of admission was far greater during the first 3 months following childbirth than at any later point. The differences in attitudes within the group of hospitalized mothers appear more striking than the differences between the hospitalized and nonhospitalized mothers. Mothers break down and enter a psychiatric hospital at many different points following childbirth; maternal conflict makes it difficult for these women to deal with the particular mother-child issues which are associated with the onset of these emotional disturbances. While we do not claim that maladaptive attitudes are "causal," there is an association between maternal attitudes regarding particular life issues and the development of the disturbance at that point.

Studies by others are consistent with our findings that mothers from lower social strata and older mothers express more maladaptive attitudes regarding the appropriate control of the child's aggressive impulses. Since this factor pertains to somewhat older children and is the only factor indicating a relationship with maternal education and age, it is possible that as the child grows older, cultural factors may become even more important as determinants of child-care attitudes.

Important questions remain to be answered. How do maladaptive attitudes toward child rearing change as a function of hospitalization and other forms of therapeutic intervention? What relationships among hospitalized women obtain between maternal attitudes and the child's present and subsequent adjustment? What relationship obtains between maternal attitudes and aspects of the mother's marriage and the relationship with her husband? What aspects of the mother's own pre-adult psychosocial development play a role in the formation of specific patterns of child-rearing attitudes? Additional study will provide knowledge concerning the origins of severe emotional disturbances in the years following childbirth, the means by which mothers may be helped to deal with their feelings about child care, and the factors which lead to particular mother-child relationships which have a more or less optimal effect on the child's own adjustment.

The Effects of Psychosocial Deprivation on Human Development in Infancy

BETTYE M. CALDWELL

As an explanation for certain distortions in human development, the concept of deprivation has been appealing to scientists. Whenever any approximation of a minimal level of necessary input can be established, the deprivation model appears to be appropriate as a frame of reference and to be relevant for all living organisms and to the entire gamut of developmental influences from biochemical to psychosocial. Also if one can specify the substance of which the organism has been deprived, then one should be able to supply the missing ingredients in the proper quantities at the correct time.

The logic inherent in the concept of deprivation has stimulated a vast amount of fruitful research. In general, the sequential investigations have followed something of an evolutionary pattern in terms of choice of the dependent variable. The first is usually life itself, with sublethal effects gradually added to the list of possible consequences in an order that progresses from somatic toward psychosocial. Historically, early studies stressed the effects of malnutrition on stature or brain weight—research into its effects on mental development is very current and that concerned with socioemotional development more contemplated than consummated. Something of a similar evolution has occurred with the independent variable; early efforts were devoted primarily to demonstrations of the consequences of deprivation of some biochemical substance (e.g., oxygen) with attention to psychosocial deprivation being of fairly recent origin.

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Psychosocial Deprivation in Infancy

Within this broad domain of scientific concern, it is possible to offer some generalizations. When the investigations have utilized an *experimental* model, findings have tended to be fairly consistent across a broad range of developmental influences. When hypotheses are tested in humans, forcing reliance upon a *field study* model consistency disappears, and the complexity of the concept of deprivation becomes apparent.

Some of the variance may relate to the difficulty in defining what it is we are talking about when we speak of "psychosocial deprivation."

In addition to the tendency to become alert to deprivation only after its presumed consequences have begun to appear, there is another reason to want to support the presumed presence of deprivation with proof of effect. Conceptually we are troubled by false negatives—the appearance of some children who develop reasonably well in an environment judged to be depriving, children who grow big and strong on an inadequate diet, who grow up bright and alert after having been blue and almost lifeless for 5 minutes following birth, who develop high achievement motivation in a sociocultural context characterized by apathy and defeat. An explanation is that the crucial variable may not hit all children with the same impact; i.e., some children in a family get more food than others, or the anoxic baby had oxygen reserves that could not be measured, or the last child had a special relationship with

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a powerful nonfamily member. Thus it could be asserted that it is safer to infer deprivation only when one sees evidence that it has hit its target. But the fact that deprivation defined in terms of a complex set of elements of experience needed for development exists but occasionally misses its target does not require proof of effect for presence of influence to be inferred. Developmental misses are informative about the range of human adaptability; they do not require any more conceptual elasticizing for psychosocial factors than for any other type of presumed developmental influence.

With respect to the effects of psychosocial deprivation on the human infant, there has been more speculation than investigation, or perhaps less speculation than unwarranted inference. Research with this age group is difficult, not only because of the tangles inherent in the deprivation concept but because of a shortage of assessment techniques suited to the young child and of qualified persons to apply them. Nor has there been a readily available series of research subjects—at least not to persons interested in this area. The well-child clinic has been the only major resource, and by and large it has not been utilized for such studies. And, in most communities, it would produce a biased sample.

Much of the early work emphasized "maternal deprivation." It was reported that infants who were abruptly separated from their mothers often went into a state of depression and showed a sharp decline in cognitive functioning. Implicit in this work was the importance of the emotional relationship existing between mother and infant.

It did not take long until disclaimers appeared, suggesting that proponents of the maternal deprivation concept might be overstating things. The coup de grâce to the indiscriminate espousal of the concept of maternal deprivation was supplied by analyses of empirical studies which challenged the notions of inevitability and irreversibility of effect and which pointed out design flaws in most of the studies. The concept of maternal deprivation as an independent variable was broadened to take in the entire psycho-social-cultural domain. Again, there was a tendency to indict an entire package rather than look for those aspects which were most crucial.

It was interesting to note how quickly the infant got lost. Not the importance of infancy, just the infant. Studies which appeared in the early sixties contrasting the developmental picture of children who were culturally deprived (to use the term then fashionable) and nondeprived groups tended to show that by the time the children reached public school age they already functioned at a lower level than their nondeprived peers. This was interpreted as indicating that the depressing effect of the environment had already been at work during the early years of life, even though the research groups had not studied their subjects during that period.

Field Studies of Early Deprivation

Some of the early leads regarding psychosocial deprivation came from studies concerned with effects of different child-rearing practices. In an early study of child-rearing practices in different ethnic and social class groups, it was suggested that the early family environment of the lower-class child was perhaps more comfortable, in terms of parental practices, than that of the middle-class child. Lower-class parents reported themselves to be more indulgent in terms of early

feeding practices and to be less concerned with early toilet training than did middle-class parents. Also they were interpreted as being more willing to grant independence as their children grew older. Class differences were more striking than race differences.

Less than a decade later, data suggested just the reverse pattern. That is, maternal interviews with parents of 5-year-olds brought forth the information that middle-class parents were more lenient and permissive than the lower-class parents. A number of researches subsequently carried out tended to support these findings or to find no appreciable differences between social class groups. It was suggested that the tenor of the postwar period was in favor of permissiveness and that middle-class parents, with their greater susceptibility to opinions of the "experts," had probably assimilated the recommendations more rapidly than lower-class parents. At any rate, no data have emerged since the early fifties to suggest that the child from what might be considered deprived social circumstances has any particular psychological advantage in his early family environment.

Most of these studies used as contrast groups samples that perhaps did not differ drastically along a hypothetical continuum from deprived to nondeprived. The groups might be described as upper-lower versus lower-middle. In more recent years, careful studies of groups that could be characterized as truly deprived have been carried out. In one study, it was found that what might have been called permissiveness in another decade appeared to be more a lack of concern. Weaning and toilet training were handled inconsistently and in the manner that caused the least trouble for the mother. The mothers were intolerant of any expressions of aggression from the children but were relatively unconcerned about manners, noise, and cleanliness in general. Also the mothers themselves were depressed and withdrawn and pessimistic about life. Independently assayed, i.e., not judged on the basis of development of the children, psychosocial deprivation was a demonstrable reality. Here it should be mentioned that all the children in this study had been born prematurely, thus compounding biological insult with psychosocial deprivation. The children involved, now in the middle childhood years, are being followed to learn about their school achievement and general social and emotional adjustment.

The maternal behavior of a small sample of low-income mothers was observed and rated sequentially and the children were examined at the same points in time. The data offer leads regarding the relation between discrete maternal behaviors that would be considered depriving and the development of the children during the infancy period. The results showed that on scales purporting to measure some aspect of emotionally supportive maternal behavior, mothers who were rated lowest had children with lower IQ's at 12, 18, and 24 months of age. Similar associations were found for scales measuring different facets of achievement motivation in the mothers. In general, at 12 months, the correlation between affiliative and achievement-oriented maternal behavior and development tended to be low and positive, with the number of coefficients attaining statistical significance and their magnitude increasing as the children approached 2 years of age.

With the intensified interest in cognitive development in the sixties

has come a renewed interest in instrument development for the early infancy period. This interest, coupled with concern for psychosocially deprived children, has led to a number of studies examining early differences betwen infants being reared in suspect environments and those being reared in environment labeled by fiat as adequate (i.e., middle-class homes).

Two recent studies have produced somewhat contradictory results. One found social class differences as early as 12 months on an ordinal scale which measures attainment of the concept of object permanence. Another study was unable to demonstrate social-class differences in test scores of Negro infants during the first 2 years of life on either a standard test of infant development or an experimental procedure developed to measure more subtle aspects of cognitive function. It did, however, find that the children from lower social class groups were more difficult to test. This finding, whether due to motivational factors or to difficulty in adjusting to the interpersonal components of the test, somewhat weakened the conclusions of no social-class differences in performance.

Another study has yielded important data relating to the effects of psychosocial deprivation during infancy. It was concerned with determining whether Piaget's concept of "object permanence" bore a relation to the psychoanalytic concept of "object relations." The population was 30 home-reared infants, 30 in adoptive homes, and 30 in an institution. Results showed the damaging effects of the psychosocial deprivation inherent in the institutional atmosphere; on both the measures of object permanence and object relations the institutional infants lagged behind the other two groups, showed deviant as well as delayed developmental profiles, and were far more variable. The children in adoptive homes occupied an intermediate position between the institution and home-reared infant.

The important question of what happens between the end of the 1st year and age 3, at which time at least a few children come under research scrutiny, remains a research problem of top priority. Early studies tended to show no *major* differences between infants presumed to be nondeprived and a group that might be considered deprived of one or more developmental supports.

All available studies are consistent in their implications. During the first year of life infants from deprived and nondeprived homes appear to develop at about the same rate; we tend to lose track of them from 1 to 3 years of age; when found again at age 3 the deficit is striking (and resistant to sustained change). Such findings suggest that the optimal time for trying to reverse the deprivation is during the 2-year hiatus when subjects are seldom visible to research scrutiny.

Experimental Studies Relevant to the Deprivation Model

With human subjects, one cannot point to a truly experimental study that involves deprivation. The only pattern ethically open is to try to reverse deprivation—i.e., to enrich—and examine the effects. The earliest important study of this nature was the project in which 13 children showing retarded development in an orphanage were transferred to an institution for the mentally retarded. In this new environment, hardly one likely to be thought of as enriching, the infants were cared for by adolescent and young adult mentally retarded girls. Instead of being part of the crowd having to share the scanty amount of adult attention in the orphanage, the children were cyno-

sures in a population probably starved for small, dependent creatures. The story has the happiest of endings. Most of the children became adoptable and, when found and studied some 30 years later were able to maintain themselves in the community and to have produced offspring that functioned within the normal range.

Another important study aimed at determining whether the amelioration, if not the removal, of psychosocial deprivation would produce favorable developmental consequences involved a "congregate mother" for two groups of four infants residing in an institution and eight matched subjects as controls. After 2 months of special mothering, the infants were examined on eye-hand tests and on social development. The experimentally mothered infants were found to be more socially responsible, not only to their special caretaker but to other people on the ward, and to be slightly advanced in postural and motor behavior.

These infants were reexamined when they were approximately 2 years old. At this time no differences between the two groups of babies were detected, either in terms of social behavior or performance on a developmental examination. However, the investigators seem too conservative in their conclusion, as the enriched babies were found on followup to vocalize more than the control babies. The relationship between early vocalizations and later language is far from understood, but in view of the consistency with which deprived children are shown to function less adequately in the language area, any social experience associated with an increase in vocalization is worthy of study.

Areas of Needed Research

It is obvious that the need for more research dealing with the problem is acute. A few tasks which should receive massive research efforts are:

Improved techniques of assessing the psychosocial environment — Behavioral scientists have concentrated on measuring behavioral outputs, while paying little attention to the environments in which the behavior occurred — all the while espousing convictions about the importance of environmental influences. This imbalance needs to be corrected by research concerned with identification of the elements of experience which can influence development and to studies of their incidence and distribution in populations known to contain all levels of the dependent variables.

Change-sensitive measures of early child development—Another important need is more attention to the development of change-sensitive measures of human behavior. Involved here would be naturalistic observation techniques which make use of nothing more quantitative than a frequency count. The work of those who use operant procedures to induce behavioral change exemplifies utilization of change-sensitive behavioral measures. The experimental paradigm involves the deliberate selection of a variable which is expected to change when maintaining or reinforcing conditions change.

Exploring the relationship between constitutional factors and the susceptibility to the influence of deprivation—There is need to consider the inherent characteristics of children exposed to different types of early experience when looking for evidence of environmental influence. This, of course, is but a reiteration of the position taken by those who stress the importance of constitutional factors as buffers against the vagaries of experience.

Research utilization of the clinical

single-case model—The task of providing proof of effect of malnutrition and of psychosocial deprivation is similar. In cases of suspected malnutrition, investigators have often had to rely on evidence from the dependent variable to infer the magnitude of the independent variable—i.e., to infer nutritional status from growth for age—in that only after children are found to deviate from growth norms do they come to the attention of persons who can offer remediation. But, discovery of height-weight deviation does not always herald malnutrition, as the infant may be manifesting a genetic potential for small stature. A careful inquiry may confirm the malnutrition, and clinical action will be taken to rectify the inadequate nutrition. In the logic of diagnostic procedure, subsequent measures of height and weight which indicate movement toward growth norms are not proof of the accuracy of the diagnosis. Equally necessary is a check to determine whether food intake has actually changed during the interim in the direction that had been prescribed.

In cases of suspected psychosocial deprivation observed clinically, this model has generally been followed, but often only part way. For one thing, similar evidence—deviation of developmental rate for age norms in the absence of evidence pointing to biological causation—is often the first indication that psychosocial stimulation might be inadequate. (It is the *first* indication only in the way that appearance of a malnourished child forces recognition that the food supply of a population is inadequate. All sorts of other signs are clamoring to be perceived, but until there is clinical concern it is easy to overlook them.) In the second place, attempts to alter psychosocial input offer about the only remediation available; if the deviation is due to genetic causes there is little that can be done.

Here the similarity breaks down, for it is easier to specify the minimum daily requirements of nutrition than it is to supply the same for experience. Even so "remediation-as-proof" is justified, provided one does not short circuit the procedure necessary for establishment of full proof of effect. There is no question but that remediation of the psychosocial environment should begin, as all the evidence suggests that the longer the delay the less hope for complete remediation. However, immediate remediation without assessment of the environment in which the child is developing deprives a case of its opportunity to contribute to the needed foundation of evidence in this area. Only the full chain—deviant development, evidence of deprivation, alteration of psychosocial environment, change in developmental rate, and evidence of change of level of psychosocial stimulation—can offer the needed proof of the effects of the environment on the infant's development.

As an epilogue a note of caution should be added. Concerned people tend to pair "deprivation" with "enrichment." But enrichment is not necessarily the antonym of deprivation. Manipulations of experience may be useful only up to an as yet undetermined safety level. To go beyond this level in our fervor to counteract deprivation may be like giving vitamins to a well-fed child—his system will just disregard the excess. It may even be by like overloading the small world of a premature baby with too much oxygen and damaging the cells of his retina. This is not to suggest that "experimental hyperplasia" will inevitably occur following psychosocial enrichment, but rather to serve as a reminder that it *could* occur.

Severe Psychiatric Disorders of Childhood: Electroencephalogram and Clinical Correlates

Janice R. Stevens and Victor Milstein

During the diagnostic study of children with severe psychological or behavioral disturbances, an EEG is often requested, with the expectation that the results will distinguish organic brain disease from emotional problems. If the record is judged abnormal, this finding is variously interpreted as indicative of brain damage, epilepsy, or if results conflict with clinical impression, as irrelevant. The high incidence of EEG abnormalities among patients with epilepsy has caused particular difficulty, for the logical error of mutual identity has often led to a diagnosis of "epileptic equivalent" for a variety of nonictal disturbances of behavior and subjective state.

Minor neurologic signs, history of neurologic illness, or abnormal EEG are demonstrable in approximately half of the children with the hyperkinetic "minimal brain damage" syndrome. Less widely known is the evidence for electrophysiological disturbance among children with so-called functional psychoses of childhood. The present study is addressed to the analysis of relationships between clinical and EEG features for such a population.

The Children's Unit of the Metropolitan State Hospital (Massachusetts) admits patients aged 5 to 116 years of age with diagnoses of psychiatric and emotional disorders. Although every child admitted to the hospital from October 1, 1966 to May 30, 1967, was scheduled for an EEG, a few were missed, usually because their stay in the hospital was too short. In addition, EEGs were made on 33 children already resident on the wards who had not had a record made previously. Using no other means of selecting and excluding no EEGs recorded during this 8-month period, 100 children were available for study.

A medical and social history was taken by the psychiatric social worker, and supplemented by the psychiatrist to whom the patient was assigned. The medical and neurological examination was performed by the hospital pediatrician, and in many instances by the consulting neurologist. Psychological evaluations of most children by staff psychologists included intelligence testing with the Stanford-Binet or Wechsler Intelligence Scale for Children or Merrill-Palmer and Vineland Social Maturity scale. Rating sheets listed 39 behavioral measures which were graded absent (0), mild (1+), moderate (2+), or severe (3+) for each child by the ward physician or nurse. All data were punched on cards, and the incidence of clinical and EEG abnormalities for the 100 children was compared with that found in 87 normal control children and 97 "hyperkinetic" outpatient children who have previously been studied by us in a similar manner.

The subjects represent a heterogeneous group of disorders ranging from repeated unexplained antisocial acts by children or adolescents without evident psychosis, to the most severe psychotic disturbance dating from early infancy or childhood. Ninety-one percent of the hyperkine-

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tic children were boys in contrast to only 73 percent of the hospitalized children. Birth-natal complications appear equally often and are in general similar among the Metropolitan State Hospital children and outpatient children with behavior disorders and are significantly increased over controls. A family history of nervous and mental disease and major disturbance in interpersonal family life (parent-sib relations) are similarly increased in the two groups of disturbed children compared with controls. The higher incidence among the Metropolitan State Hospital children of significance pathology in previous medical history and of strabismus was unexpected. Twelve children had severe abdominal pain either in infancy or in close proximity to the onset of the psychiatric illness.

Although the incidence of abnormal EEGS was essentially the same for this group of children and the previously evaluated hyperkinetic outpatient group, some differences in the type of EEG abnormality were found. The spike-wave response to intermittent photic stiimulation (IPS), elicited in 11 children, distinguished a Metropolitan State group from both the outpatients and the controls. Among the 11 children with spike-wave response to flicker, six had a diagnosis of character, conduct, or impulse disorder, usually marked by extreme violence directed toward the self or other persons; five were girls; four were diagnosed child psychotic; and 73 percent had a family history of significant mental disease compared with only 37 percent of the total sample of 100 children. Five were receiving therapeutic doses of phenothiazines. Among the seven children with a diagnosis of character disorder, five exhibited spike-wave to light.

Focal abnormality—Analysis of the regional distribution of abnormal wave forms recorded from the scalp indicates a positive relationship between EEG abnormality over the *frontal* region of the head and hyperactivity. Difficulties with comprehension, history of hallucinations, and family history of nervous and mental diseases are related to *parieto-occipital* abnormality. Only a previous history of abdominal pain correlates positively with EEG abnormalities over the *temporal* regions. No association is demonstrable between aggressivity or antisocial behavior and abnormalities localized over the temporal lobes. *Diffuse* EEG abnormality was correlated with an abnormal neurological exam, strabismus, disturbed speech, bizarre habits, social withdrawal, a discrepancy greater than 14 points between verbal and performance IQ, and treatment with phenothiazines.

Abnormal wave forms—The global (overall) diagnosis of abnormal EEG in these children is associated with many clinical characteristics: speech disturbance, verbal-performance IQ difference greater than 14 points, variability, hallucinations, clumsiness, open masturbation, unusual mannerisms, and abnormal birth-prenatal history. Excess *slow* EEG activity for age is associated with many of these symptoms as well as social isolation, body complaints, abnormal birth or prenatal history, family history of nervous and mental disease, history of medical or neurological illness, and drug treatment. Spike or *spike-wave* activity is associated with rather different clinical items; bizarre mannerisms, hyperactivity, negativism, unusual food habits, posturing, mental retardation, impulsive behavior, and disturbed family life (parent-sib relationships). In general, the slow EEG seems to relate to disturbances of intellectual and motor development, while the spike-wave at

rest and with light is associated with behavioral and emotional instability.

Of the 4,927 cross correlations computed, 627 were significant at or beyond the 5 percent level. A number of these items are of special interest. Aggressive and antisocial behavior relate to disturbed family life (parent-sib relations) and low socioeconomic status. Hyperactvity is associated with several other characteristics often deemed "organic," viz., impulsivity, variability, open masturbation, and short attention span, but not with abnormal neurological examination. The latter is, however, related to posturing (catatonia, bizarre automatisms), perceptual defects, diagnosis of child psychosis, and personal history of past medical or neurological disease. Delinquency has no positive correlates among historic or neurological factors, but is *inversely* related to disturbances in comprehension, compulsivity, hyperactivity, and psychosis. Diagnosis of child psychosis (including autism, atypical child, and schizophrenia) relates to a number of items usually requisite to this diagnosis, but not to parent-sibling relations.

A multivariant analysis was undertaken in which interactions between environmental and genetic-organic items were sought in relation to the EEG characteristics. Family history of nervous and mental disease and past history of severe neurological or medical illness were examined as the genetic and acquired predisposing organic factors, respectively, and parent-sib relation was the single environmental measure scored. The environmental factor (which subsumes any major disturbance in family life, including parental separation, child neglect, abuse, desertion, etc) positively correlated only with impulsivity, aggression, and family history of nervous and mental disease. However, an interaction analysis demonstrates that the positive relation of poor environment to impulsivity and aggression obtained only for children with diffusely abnormal EEG, while the relation between family history of nervous and mental disease and poor home environment was independent of EEG type.

Spike-wave to light—The tenfold increase in incidence found for the spike-wave response to IPS in the disturbed children compared with normals agrees with observations of others. Although five of the 11 children with spike-wave response to light were receiving phenothiazines, drugs which are known to foster paroxysmal EEG activity, no tendency for these agents to alter the response to IPS was noted.

Environmental factors—Although all environmental factors were scored under "parent-sibling relations," only aggressivity, impulsivity, and family history of nervous and mental disease correlated positively with this factor. Autism, delinquency, psychosis, and character disorder did not. However, when interactions were sought between environmental handicap and all other measures among children in each individual EEG category, only children with spike or spike-wave on EEG demonstrated a positive relationship between disturbed environment and diagnosis of psychosis. Similarly, although disturbed parent-sibling relations and impulsivity or aggression were related for the group as a whole, no relation between these factors could be shown for children with normal EEGs; the positive correlation was to children with spike, spike-wave, diffusely abnormal, or slow records. The relation between a history of abdominal pains and spike-wave on EEG suggested a possible metabolic disturbance. However, investigations to date have yielded small returns.

Autism and EEG—Among the children with a diagnosis of early infantile autism, five had normal "hypermature" EEGs and none demonstrated the spike-wave pattern. It may be that, like hypsarhythmia, spike-wave in the EEG of autistic youngsters is characteristic of only the early stage of the illness. Several children diagnosed autistic or schizophrenic had a single channel EEG recorded by radiotelemetry during free "play" which consisted of solitary hand fluttering, rocking, high pitched cries, darting sudden movements, staring, or temper outbursts. None of this typical repertoire of autistic behavior aberrations was associated with any recordable seizure activity or other pathological change. We were impressed in several "autistic" children with the unusual persistence of alpha rhythms during evident visual fixation of objects or loud noises, and disappearance of alpha only when staring at their own hand-fluttering movements or during sudden darting or patting automatisms. Similarly, we have been unable to show that the episodic blocking of thought or speech found in many young schizophrenic patients is associated with alteration in scalp EEG. Our failure to discern changes in the scalp tracing by visual scan does not exclude the possibility that abnormal electrical activity in subcortical structures may be associated with the episodic behavior aberrations or psychosis.

Drug treatment—The presence of spike activity in the EEG, either at rest or in response to photic stimulation, has not been a reliable indication that anticonvulsant therapy will ameliorate the psychiatric disorder. On the contrary, several children with severe acute psychoses, which rather resembled psychomotor fugues, were either not helped or even made worse on diphenylhydantoin or phenobarbital. We have not sufficiently explored the use of other anticonvulsants to state that they are without value, but it is our impression that these anticonvulsants were not effective for psychotic children despite paroxysmal sharp, spike, or slow activity in the EEG. This is in contrast to the treatment of children with hyperkinetic behavior disorders, among whom we found several with paroxysmal EEGs, but without seizures, whose symptoms were alleviated by anticonvulsant regimens.

In two psychotic children whose behavior included restlessness and extreme hyperactivity, some diminution in these symptoms was achieved with amphetamines; however, self-destructive behavior, such as severe nail biting, finger and toe chewing, or face scratching, was increased. Serious aggravation of aggressivity and irritability followed modest doses of dextroamphetamine in isolated cases. Phenothiazines were more often useful in the management of psychotic reactions regardless of the EEG pattern. Similar observations have been made with respect to certain individuals with seizure disorders who develop severe behavior disturbance or psychotic episodes during anticonvulsant treatment. Under these circumstances, the aggravated psychiatric symptoms may be remarkably alleviated by addition of phenothiazines to the anticonvulsant regimen, suggesting a reciprocal relationship of anticonvulsant drugs and the alpha-adrenolytic tranquilizers.

This study of severely disturbed children hospitalized for psychiatric disorders demonstrates significant correlations between physiological and clinical factors. The correlations, while they do not permit inferences concerning causality, suggest that cer-

tain regional or wave form abnormalities in the EEG are more likely to be associated with a given clinical symptom or sign than are others. The recording of an abnormal EEG, even with the paroxysmal spike or spike-wave configuration is not pathognomic of an epilepsy. Furthermore, a normal scalp tracing does not permit the exclusion of underlying structural or physiological abnormality of the brain. Not only were abnormalities of the neurological examination neither positively nor negatively correlated with EEG findings, but normal EEGs may be recorded in patients with evidence of cerebral pathology, particularly of subcortical origin.

The associations demonstrated between clinical pathology and regional or wave form abnormalities suggest that structural or physiological pathology may underline many symptoms characteristic of child psychosis. Although the incidence of social and interpersonal disturbance was high among these children, the vexing attempt to dissect out the relative contributions of "nature" and "nurture" indicated a positive relationship between the child's early family and social environment and only three clinical items: diagnosis of psychosis, pathological impulsivity, and aggression. Moreover, since these relationships held *only* for children with an abnormal EEG, it appears that environment alone was not associated with even these factors in the child with a normal record. Not unexpectedly, a past history of severe neurological or medical illness was inversely related to environmental handicap for children with EEG abnormality. Although the genetic factor, family history of nervous or mental disease, was related to environmental handicap for the group as a whole, this relationship was reversed for children with diffusely abnormal records. This suggests social selection of environmental handicap by persons of poor endowment and a relative independence of EEG and environmental factors.

Investigators who have followed severely disturbed children over many years have indicated the frequency with which a grave outcome is to be anticipated regardless of treatment method. Exploration of etiology is urgent. Inclusion of the EEG in the diagnostic evaluation can be of value only if the significance of recording a normal or abnormal pattern is defined. Acceptance of the significance of physiological predisposition to psychological illness is often eschewed because of the supported immutability of physical handicaps. As recent developments in physical and chemical diagnosis and treatment methods have shown, however, drug therapy, diet, enzyme replacement, and special training of motor and mental skills can be useful if treatment is begun before irreparable physical and social damage occur.

While most epilepsies are associated with abnormal EEGs, an abnormal EEG does not necessarily signify an epileptic process. Even the EEG spike is not infrequent in the severely disturbed child without convulsive disorder. The abnormal EEG found in nearly half of the children with psychiatric disorders suggests associated biochemical or physiological abnormalities, which lead to both characteristic behaviors and regional disturbances in brain function. Identification of these may lead to more specific and successful treatment programs.

The Child Development Consultant: An Experiment

ERIC SEIDMAN, MARK B. PETERSON, RICHARD HILL BYRNE, AND CHAUNCEY M. DAYTON

Educational accomplishment can be retarded by social, emotional, and learning problems. As a consequence, attention is being given to the introduction of pupil services in elementary schools to identify and remediate these problems at the earliest possible time. Although no definitive rationale has emerged to serve as a guide for implementing pupil services, nonteaching professional personnel are being hired for placement in elementary schools.

The project reported here stemmed from a recognition of the need for data around which to construct a rational basis for functions of pupil service professionals at the elementary school level.

The Interprofessional Research Commission on Pupil Personnel Services (IRCOPPS) was composed of representatives from 13 professional organizations and was funded by the National Institute of Mental Health. Four universities were selected as regional centers with the University of Maryland being named as the Eastern Regional Research Center. Each center selected its own areas of research; the Maryland Center undertook an investigation of services at the elementary school level. The major project was concerned with the evaluation of the relative effectiveness of counselors and social workers trained and oriented in a "traditional" manner and experimental workers known as Child Development Consultants (CDC).

The roles and functions of the CDC were defined as those which would help to create conditions in the school that support maximum development of all pupils, and to discover and carry out those functions that lessen or remediate problems for students in need.

The CDC's met each week on campus for a 2-hour seminar under the direction of the associate director of the Maryland Center. The topics evolved from the problems confronted by the trainees in their schools. The process of identification, definition, analysis, and resolution of the problems was aided by invited professionals from medicine, psychiatry, psychology, social work, special education, and criminology. The conceptual framework was oriented toward providing the CDC with a variety of role models and methodological approaches. Roles and functions were allowed to evolve on the basis of needs manifested by pupils or expressed by teachers and principals in the schools where the CDC's served as full-time staff members.

The intent underlying the project was one of discovery, i.e., the project would provide data potentially valuable to elementary schools making decisions on whether or not they wanted to implement various types of pupil personnel services. The concept of the CDC was developed so that some schools would be staffed by workers who were free from professional identifications that had evolved at other educational levels. The role of the CDC was to be evolutionary in the sense that the functions carried out would be adaptations to existing problems and concerns. The major research problems were:

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Is pupil behavior more adaptive in experimental schools having CDC's than in comparable nonexperimental schools?

Is there evidence of change in teacher behavior and attitudes in schools having CDC's as contrasted with teachers in nonexperimental schools?

Will experimentally evolved functions of CDC's differ from traditional patterns?

Thirty-one schools enrolling approximately 15,000 students and staffed by over 500 teachers were involved. Most schools participated for 3 years. Schools were divided into three groups:

Control schools—16 schools having no in-school pupil personnel worker; some services were available upon request.

Traditional Worker schools—six schools having traditionally trained and oriented professional workers (counselors and social workers) assigned on an in-school basis.

CDC schools—nine schools having experimental Child Development Consultants assigned on an in-school basis (one CDC served two small, neighboring schools).

The research scheme involved evaluation of students, teachers, and pupil personnel service workers on a large number of variables. The categories of assessment included: student academic achievement as measured by standardized tests; student attitudes toward themselves as learners; teacher ratings of pupil behavior in classroom settings; teacher ratings related to attitudes toward children, etc.; teacher ratings of the success of the pupil personnel services worker; and activity sheets maintained by the in-school workers in Traditional Worker and CDC schools.

The general findings are:

There was no evidence for a differential effect on student achievement among the three types of schools.

While no consistent trends were noticeable during the first 2 years of the project, there was evidence of a more favorable pattern of self-concept for students in schools staffed by CDC's during the third project year.

Teacher ratings of pupil classroom behavior showed no consistent trend in any of the types of schools.

The presence of an in-school worker (Traditional Worker or CDC) had a sensitizing effect upon teachers, in that more students tended to be nominated as needing professional services. These results are based on teacher nominations in terms of need for services and not on actual referrals for professional assistance.

When comparing Traditional Worker and CDC schools, the types of problem areas which resulted in teacher requests for assistance from an in-school worker were similar and were stable over the 3-year span. Academic progress and emotional development problem areas each accounted for above 25 percent of all requests, while classroom behavior and social development were responsible for about 20 percent each. The remaining 10 percent was spread over a variety of miscellaneous categories.

With respect to students for whom assistance was sought, there was no consistent pattern suggesting greater improvement in the Traditional Worker or CDC schools.

The results from the activity sheets revealed that in some areas the CDC's were evolving a distinctive pattern of functions which represented an integration of certain aspects of the configurations displayed by counselors and social workers.

CDC's and counselors were similar

in that they served students representing all grade levels, both showing few contacts with special education students; social workers had about 13 percent of their contacts with the special education category.

The functions of both CDC's and Counselors involved remediation of student problems in about 50 percent of the contacts, whereas this figure was about 70 percent for social workers.

Counselors in general showed no visits to students' homes in order to carry out their functions; both CDC's and social workers made home visits. However, the majority of functions were performed in the school.

CDC's differed from counselors and social workers in reporting fewer functions as self-initiated, and more functions as initiated by request of a school staff member. All three were essentially the same in responding to requests from parents, pupils, other workers, and miscellaneous sources.

Perhaps the strongest single statement permissible on the basis of the data collected is that experimentally conceived pupil services workers allowed to evolve their own in-school roles and functions performed no worse than traditionally trained and experienced workers. Moreover, there is no clear differentiation between schools with workers and schools without workers. Although in-school workers of all types were rated by teachers and staff members as performing well, this was not necessarily reflected in student academic achievement, ratings of student behavior, student ratings of self-concept, and other measures.

While overall the CDC resembled an elementary school counselor more closely than any other single model, there was evidence that the CDC incorporates certain functions which may make this type of worker more desirable and more adaptable than others (e.g., the tendancy of the CDC to make more home visits and to be more responsive to requests for initiation of services from staff members rather than being self-initiating).

The findings suggest that a school district must first decide whether or not any in-school services at the elementary school level are necessary (beyond those available from school-district-based workers), and then whether or not one specific pattern of roles and functions is more desirable than the others. The methodology of this project may be adaptable to local conditions. Taking into account local conditions and needs, workers with no particular professional allegiance could be placed in elementary schools with training and supervision on an inservice basis. It appears reasonable that for such workers roles would be likely to evolve which would benefit local conditions. This procedure has the basic appeal of avoiding stereotypic role definitions and may lay the foundation for an interdisciplinary approach to providing pupil personnel services at the elementary school level.

Child Advocacy and Ecological Planning

WILBERT W. LEWIS

The Joint Commission on Mental Health of Children has made as its major recommendation the development of a nationwide network of child advocacy that will insure to every child whatever services, programs, and resources may be required to facilitate his normal development. The structure of its implementation would include agencies at the Federal, State, community, and neighborhood levels with a mandate to see that appropriate health, mental health, educational, and welfare services are available to avoid or mitigate developmental problems of all kinds. The neighborhood Child Development Council would be the heart of the system. It would be responsible for monitoring the progress of each child in its jurisdiction, making referrals to service agencies, evaluating the effectiveness and availability of services, and introducing new programs as needed with Federal funds.

In spite of many problems the idea of child advocacy is appealing and deserves to be evaluated in careful demonstrations.

How might we begin to work toward programs of child advocacy, assuming that the beginnings must be modest, making use principally of resources present in our communities, that we must attend to improving treatment as well as prevention, and that we must provide ourselves an opportunity to learn before moving into community-wide programs affecting the whole range of services for children? While no existing social institution is ideally suited to provide the coordinating and planning functions implied in child advocacy, the public elementary school may have potential because of its location, the definition of a population of children it serves, and by positive attitudes of citizens toward public education. Education would need to be redefined as total facilitation of children's development from infancy on. While the school and its advocacy system would not necessarily provide all services that children need, it could provide monitoring and coordination.

Developing Child Advocacy in a School

The following is an outline of the way a program of child advocacy might be developed in a single public elementary school. It assumes that there is in the community a range of services that vary in quality and could be improved by coordination and consultation, that some needed services will be missing, and that assessment of what is needed can be made only by those who are involved with obtaining services for children in that community.

Three stages of development are envisioned: (1) Crisis intervention on behalf of children identified as deviant; (2) Outreach to families, recreation programs, preschools, and other child-socialization programs with emphasis on early identification, prevention, and initiation of new treatment resources identified as missing in stage one; (3) Child advocacy programs, including new services aimed at facilitating the normal development of all children in the community.

A Conceptual Framework

A problem in articulating the ef-

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forts of workers from several disciplines is that of developing a common frame of reference. The language of mental health is concerned with deviant behavior and does not serve well in education. We need a broader conceptual framework to maximize the effectiveness of unique professional contributions and minimize confusion among collaborators who do not share a common background.

Mental health and education programs have borrowed from field biology the concept of "ecosystem" as a way of conceptualizing about service programs for children. While the biologist is concerned about hydrological cycles, mineral cycles, and energy transmission, the social scientist is concerned with communication of attitudes, expectations, and evaluations among the members of the social systems to which an individual belongs. The idea has been helpful in thinking through programs to provide service for emotionally disturbed children and may be expanded to a conceptual framework for child advocacy.

We begin with the ecosystem to which a child belongs, which means the usual behavior settings and significant people with whom he interacts. For most children this includes home, school, informal peer groups, and sometimes group activities such as a boys' club or a community recreation center. As an abstraction, the ecosystem is difficult to define but for an individual child the definition is made simply by inquiring where and with whom he spends his time. In his natural behavior settings, parents, teachers, peers and others make judgments about how well he is meeting the expectations held for his behavior. To the extent that there are clear and continuing discrepancies, there is "discordance" in the ecosystem. Discordance is usually expressed as too much or too little of some expected behavior: "He has an explosive temper, fights at the drop of a hat" (from a parent); "He's so restless, can't settle down to work on an assignment" (from a teacher); or "He picks on the little kids all the time" (from a peer). An ecological analysis considers each source of discordance as a target for intervention, based on the strategy of increasing the effectiveness of the ecosystem by solving a number of small problems, each of which might be of little consequence. Discordance may be reduced in two ways: The child's competence in highly valued areas of behavior may be increased so that he meets more of the expectations held for him; the expectations held for him may be modified by working in those behavior settings where problems usually occur to achieve a better match between the requirements of behavior setting and child behavior.

The details of a program for a child based on such an analysis will be diverse and may call upon skills from a variety of backgrounds: Training in perceptual-motor skills for a reading disability; supportive counseling for a mother with unrealistic academic expectations; a "big brother" relationship with an older student; instruction for parents in behavior management; consultation with a teacher in using specialized curriculum materials; help for a father in obtaining employment, etc.

Crisis Intervention

It is proposed that initiation of a child advocacy process begin with children who have already been identified as deviant by the four major community-wide systems with responsibility for children's socialization. The systems are education, mental health,

juvenile corrections, and social welfare. Each has its own way of defining and responding to deviance in children but all are concerned with those who are not "making it."

The objectives of this stage are: to identify children who are in trouble; to coordinate and followup on existing services for such children; to provide additional services that are needed; to evaluate the effectiveness of current services; and to establish a child advocacy board. The rationale is to increase the flow of information among the four systems to make maximum use of resources already there. There would be no new resources except personnel to provide liaison.

A problem exists in articulating the patterns of service for children; there is much overlapping, time wasted in getting referrals to appropriate agencies, lack of information about services, and children can be better served by making better use of programs already open. In the process of testing this hypothesis real gaps in the services may be revealed, such as short-term residential facilities or diagnostic resources for school learning problems, and these shortcomings will become targets for implementation in stages two and three.

For professional staff in the crisis intervention stage the child development consultant model seems appropriate. This is a new role being developed in experimental training programs to train educators with a behavioral science orientation to work with teachers and parents in identification and prevention of behavior and learning problems, consultation on behavior management and educational programing, and coordination of various treatment resources in the community. The CDC usually has a background of experience and training in elementary education with additional graduate training in psychology and special education.

While the CDC staff may be physically located in the school, they should be administratively responsible to the consortium. The CDC staff will be responsible to the child advocacy board for the coordinating and service functions and for calling attention to deficiencies in service arrangements.

Training and research will be a major concern of the child advocacy board. Even though trained CDC's are available, it is likely that experience will suggest different emphases in the training of new CDC's or the recruitment of different kinds of persons into the role.

Perhaps the most demanding task for the CDC staff and the child advocacy board during the crisis intervention stage is to plan for stage two: reaching out into the community to develop early identification and prevention programs.

Outreach into the Community

The objectives of this stage, in addition to continuing the crisis intervention programs, are: To develop systematic "early warning" techniques for children who are not yet exhibiting serious deviance but who seem likely to do so; to initiate growth-producing programs for children so identified, such as special preschool experiences or training for their parents; to initiate treatment programs identified as missing in stage one; and to monitor and evaluate effectiveness of the service components. The outreach stage is focused on individual children, although in moving into preventive programing one would anticipate modest changes in, and additions to, the system of services to children. Perhaps the most radical innovation is the aspiration of a single organization to have suffi-

cient contact with all children within an area to make a judgment that a preventive program is needed and to act on that judgment.

At least two new kinds of workers will need to be added, one a "home visitor," the other an "educational technician." The role of home visitor is critical for early identification, monitoring the progress of children's development, on-the-spot consultation to parents and other concerned adults, and feedback to the child advocacy board. He will work under the supervision of the CDC and will have consultation from specialists in mental health, education, social welfare, and corrections.

The educational technician is a specialist in the application of a particular method of intervention that might be useful. "Educational" does not imply that he works only in the school. The roles and training required for the educational specialists must await assessment of problems, but it is reasonable to suppose that perceptual training, remedial reading, remedial arithmetic, behavior management, functional analysis of social behavior, group dynamics, and parent education would be among the skills that should be represented in a group of educational technicians. Like the home visitors, the educational technicians will be supervised by CDC staff with consultation from specialists.

The home visitor and educational technician need not be extensively, or expensively, trained. The principal requirement of the home visitor is that he be able to establish and maintain rapport with families. The education technician needs to be knowledgeable in depth in a single, or a few, techniques of intervention. Consideration needs to be given to developing the "career ladder" progression of an income-producing job that is related to a degree or certificate-producing educational program for persons who might not otherwise move through academic requirements into technical or professional positions.

Research during the outreach stage will focus on effectiveness of programs but will be expanded to include longitudinal studies of systems rather than individual children.

The Child Advocacy System

The ultimate form of the child advocacy system cannot be described in detail since its components will emerge from evaluation and planning during the two earlier stages. It seems likely that stage three will examine the social systems serving children and ask, "How can these systems be modified, restructured, or augmented in order to reduce the need for treatment and prevention programs?" We may anticipate three objectives for fully developed child advocacy: to identify characteristics of child-serving systems that contribute to deviant behavior; to initiate change in systems so identified; and to evaluate the effects of that change on children's behavior. The task will be complex and assumes political overtones as one moves into the arena of institutional change. It is safe to assume that vested interests and unconscious biases exist in all organizational arrangements serving children and will make change difficult. The movement from existing-programs to child advocacy will be a test of the hypothesis that given sufficient information and concern we can make our institutional forms responsive to children's needs.

The Idealized Model of the American Family

Ray L. Birdwhistell

Except for "Government," perhaps no social form has been so broadly discussed, so idealized, so reviled, and so little understood as is the family and, particularly the American family. Social organisms from fish to man have found it necessary to order certain aspects of their lives around courtship, mating, reproduction, and care of the young. However inventive man himself has been over the ages, in the past century we may have developed a new type of organization in the so-called American family.

A unit restricted to a husband and a wife and their offspring was a useful form for a pioneering or exploration group before settlement. However, this "segmental" family could seldom become a secure base for socialization, maturation, and long-term satisfactory social living if its strength depended upon the exclusion or the secularization of loyalties to individuals or groups outside the husband-wife, parent-child range. Such a tight and limited form of family organization permits greater flexibility as new territories are opened up or as the loosening of class barriers within societies permits individual men and women and their spouses and children easier passage from one social class to another. If, in order to permit mobility, the unit is so organized as to resist all interpersonal relationships with other than immediate family members, such a unit lacks lateral supports. It must derive all its support from the impersonal structures of the society, the formalized governmental, educational, economic, and religious institutions. If the only legitimate personal relationships must come from within the unit, and if the young must leave the unit to set up another such unit, such an organization is short-lived and self-destructive, the elderly are left lonely and isolated, and the maturing young are guilty of destroying the unit by the act of maturation.

Although *the* American family has been idealized by the press and overvalued by moralists and social scientists, it is a relatively recent development. Sometime following the Civil War, two social inventions changed the direction of both marital arrangements and child care. There emerged a new concept of the ideal relationship between marriage partners: romantic marriage and the romanticized conjugal unit increasingly became the American ideal.

Romanticized Relationships

Romantic love is a concept that idealizes the feelings between a male and a female. It is not new; a number of societies have idealized this relationship and, at least since the time of the Greeks, there have been periods of varied emphasis upon this ideal in Western society. Traditionally, romantic love has been seen, however, as a premarital or an extramarital situation apart from the everyday aspects of social living.

Toward the end of the last century and during the first quarter of this century, romantic love was domesticated and extended in scope. There emerged the ideal of the romantic marriage in which one male and the one female fall in love and that love should be sufficient to sustain their relationship "until death do them part." This was a new de-

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velopment in that not only did the mating involve exclusive sexual rights and duties but all emotional response became included and negotiated under the compact. The ideal states that one man and one woman should marry one another and contract to satisfy *all* the other's emotional and physical needs. Concepts of sexual infidelity were unconsciously extended to include all personal feelings involving outsiders. Not only does this involve a secularization of all nonfamilial associations but it illegitmatizes all those associations outside the marriage which threaten to become personal. This situation is not an optimal one for the development of mutual understanding and conventions of fidelity.

The concept of romantic marriage idealized the closed, exclusive, and isolating dyad. As such it must be threatened by the appearance of outsiders, including children born to it. To include "parenting" as the natural extension of being a husband or wife does not reduce the strain upon the pair. As if this ideal were not enough to impose upon man, a second invention completed the nonsense. This was the invention of defining parents not only as legally, morally, religiously, and economically responsible for their children, but also as responsible for the personalities of their children. As personality became a result of "proper" child care and child care the final responsibility of the parents, the parents (particularly the mother) were regarded as the cause of "bad" personalities.

Idealized Model of Family Life

It is difficult to know just what proportion of the American population lives in these exclusive, self-concerned, segmentalized, husband-wife, parent-child units. It is more difficult to know how many Americans use the ideal as a way of measuring their marriages and their parenthood. It is, however, obvious that this is the model presented to the public by science, in art, and by the mass communications facilities. It is the model used by legal, social, psychiatric, and clerical experts. When all agencies designed to assist men and women and children in trouble accept as ideal the condition which occasioned the difficulty, the devices for ameliorating social pathology contribute to it.

The ideal has far-reaching results and breeds its own mythologies. We have described our culture as child centered and have felt the children to be unappreciative of the attention given them. I am not sure this is true. It would be better to say that we have become a "marriage and parenting-centered" society, with the children a necessary component of it. The behavior of the child is given attention as a measurement of the marriage or of the parents as parents. The child says, "You don't care about me; you are only thinking of yourself." This makes little sense to the anxious parent who is constantly concerned with whether he or she is "doing the right thing with the child." Neither does the parent who tells the child, "Everything we do is for you and we want you to make us proud," make much sense to the child. Such statements as these delight the "expert" who sees the parent-child difficulty as a consequence of the failure of parents and children to communicate. In my opinion we miss the point when we focus upon the ploys, the recurrent tactics of action and reaction within the family. Such a view obscures the fact that the institution itself is distorted and must be reorganized. Unless the family unit can be expanded and its members supported in larger social relationships, we can give little more than first aid to its members.

Detrimental Effects of the Idealized Model

I cannot be objective about my dismay at the mischief occasioned by this American family ideal. One aspect of the conflict in America is the so-called generation gap. This concept is useful for pointing out the recent extraordinary acceleration of social time and for directing our energies toward revision of increasingly outmoded legal, economic, educational, and religious formulations and structures. Unfortunately, *generation* translates *parent* and *child,* and as the adult deals with or reads about the young, he does so as a guilty or insufficiently appreciated parent; as the young attempt to deal with the adult world, they operate by the same logic. Necessary social changes become points of nonproductive, intergenerational conflict when the adversary method is reduced to an extended family squabble. Creative energies are dissipated when the angry child tries to engage with the guilty adult in a way directly related to the idealized family sphere. The child has been instructed by the parent that his (the child's) personality success or failure can be related to the acts of commission or omission on the part of the parents. When the child accuses, the parent accepts the charge in submissive impotence or is resentful because the child is insufficiently grateful for what the parent has been able to do. The fact that all adults become the "establishment" makes negotiation outside the family difficult. Angry, reactive Government officials can confirm the adolescent conception of the outside world (as well as acting out the exasperation of the guilty parent); the equally reactive adolescent rebel leader fulfills in his actions the projections of the guilty parent. It is not surprising that the self-designated representatives of the adult establishment and the self-selected spokesmen of the disappointed adolescents disdain education, social science, and psychiatry and scorn those moderates and liberals who see choices other than those of armed rebellion or armed suppression.

It is amazing that so many people have withstood the force of such a pathogenic institution and have achieved a reasonable adaptation to living with other people. The number of reasonably well-adjusted human beings in American society is a testament to man's flexibility, his ability to withstand a destructive environment, and his capacity for resistance to impossible idealizations.

It would be naive to believe that the present turmoil throughout the world is a result of "bad families," "bad mental health," or the failure of communication between the generations. Such reductionism is obscure and exhausting at a time when we must direct our energies to the solution of critical domestic and international problems.

We would not have a healthy society simply if husbands and wives understood each other better, or if parents and children could be directed toward less destructive interaction. If, however, we could reduce the pathology inherent in the present family ideal by unmasking its impossible goals, we might have better access to the talent and energy so wastefully employed by so many unhappy and dissatisfied people.

But the problem cannot be solved as long as our lawmakers, clinicians and moralists accept impossible ideals and operate in terms of them.

Evaluation of a Mental Health Consultation Service in a Ghetto Area

Saul Scheidlinger, Elmer L. Struening, and Judith G. Rabkin

As community mental health programs have mushroomed during the last decade, the importance of mental health consultation has been increasingly acknowledged. Despite the current enthusiasm of professionals for mental health consultation efforts, little is known about the extent to which they accomplish their aims or meet the needs of the agencies they seek to service.

This paper presents the findings of an evaluation of a mental health consultation program that has operated for more than 4 years in a predominantly Puerto Rican and black section of New York City.

Begun in March 1965, the Consultation Service to Neighborhood Organizations was a part of a comprehensive mental health program in an urban ghetto that included hospital and community-based services. Nine agencies participated initially, but the program expanded to 22—nine churches, six settlement houses and youth services, and seven grassroots storefront centers. The consultation program contained four components: An agency directors' group, which met monthly and gave the directors an opportunity to exchange information, discuss community problems and resources, and plan collaborative programs; case consultation on problems of individuals or groups; agency program consultations, which emphasized technical assistance in program planning; and training workshops for agency staffs, covering such diverse subjects as short-term counseling, sex education, and arts and crafts.

Twenty-one of the 22 directors of collaborating agencies participated in this evaluation. Of the nine church leaders, eight were ordained ministers, and one was a religious educator. Within this group, three were black, two were of Spanish background, and four were white. Of the six directors of settlement houses and youth programs, three were social workers, the other three were recreational workers without formal training. Four of this group were black and two were white. Of the six storefront directors, five were nonprofessionals, one was a social worker. Three were black, one was Puerto Rican, and two were white.

The questionnaire contained 21 items that ranged from factual inquiry, e.g., 'How long have you been in your present job?" through ranking tasks ("Rank the four program components in order of their importance to community organizations"), to open-ended queries ("What do you think the Consultation Service is trying to accomplish?"). The questions sought to elicit the directors' evaluations of each of the four programs components, to determine the extent to which the Consultation Service influenced member agencies, and to elicit areas for program modification and expansion.

Each director received a letter from the Center's Research Division inviting his participation in the evaluation. He was told that he would be approached by an interviewer who was not a member of the consultation staff, and who would ask him a series of questions about the consultation program. The purposes of the study

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were presented: How the program had worked out. In what ways has it been most and least effective. How it might be improved. Anonymity of response was assured, and the directors were told that their answers would in no way jeopardize the job security of the consultation staff since we were trying to evaluate a *way* of delivering a service, and *not* the staff personnel.

The total number of respondents was 20 because one director could not be interviewed in time and the responses of another were too fragmentary to be tabulated.

At the time of their interview, the directors had been in their jobs an average of 3¼ years. Administrators of church programs had a higher average tenure (5 years) than storefront or settlement house directors (1 year, 10 months each). The church programs and settlement houses had been involved in the Consultation Program the longest, with the storefront agencies having been in the program only a little more than a year.

Two directors claimed insufficient familiarity with the individual components to rank them, so that the obtained results pertaining to ranking are based on 18 responses.

In general, the directors' group meetings and the staff training workshops were far more enthusiastically received and appreciated than were either case or program consultation efforts. Least successful was program consultation, which was thought to have been "offered best" by only one director.

The same results were obtained by a group of items asking respondents to rate each program component separately. Directors' group meetings and workshops received ratings between good and excellent, while the two consultation undertakings (case and program) were assigned lower ratings, between fair and good. Directors of storefronts tended to assign lower ratings to the directors' group meetings, but the differences in scores by type of agency were otherwise negligible.

The workshops receiving most favorable comment were, in order of popularity, arts and crafts and short-term counseling. Workshops that were positively cited by one or two respondents were those on sex education, leadership skills for adolescents, working with groups, and understanding alienated youth. The least popular workshop was "The Role of the Agency in the Face of Militancy." The primary objections were that no militants were invited to participate and that the staff members leading the workshop really did not know what it was all about.

The respondents were asked whether "the Consultation Service should be enlarged, or cut down, or kept at its present level." Suggestions for program modification were also elicited. The answers show that 11 respondents favored expansion, nine recommended maintenance at the present level, and none wanted a reduction of services.

Several respondents suggested structural or substantive additions or changes. It was recommended that Consultation Service staff include more Spanish-speaking members and that workshops be held in the evening as well as the daytime to accommodate volunteer staff. It was suggested that Consultation Service not only teach methodology (e.g., counseling), including such new areas as formation of social action groups and lobbying tactics, but also provide resource information regarding such

problems as welfare and housing. Other suggestions included having workshops on problems of unwed mothers and addiction. One director thought that encounter groups might be rewarding. Respondents mentioned all major problems common to residents of urban ghettos—with the exception of job training and placement—as relevant and suitable for the Consultation Service's attention. It was acknowledged that no program could address itself to all of these issues simultaneously.

Consultation Service Influence on Program and Staff

Directors were asked whether they thought that the Consultation Service influenced their agency's program or themselves and their staff members. Only three respondents stated that the Consultation Service had specifically influenced their programs; the other 18 could cite no program changes attributable to Consultation Service intervention. Some noted that their programs had been organized prior to the existence of the Consultation Service, and others explained that they had not sought assistance in programing. The lack of influence on agency programs is probably related to the low rank assigned to Consultation Service's program consultation service. A factor to be considered is the possible sensitivity of the directors to any implications that their overall programs were in need of improvement.

In contrast to its lack of impact on agency programs, the Consultation Service was seen by the majority of directors as having a significant and positive effect on their staff members and on themselves. Thirteen directors answered this item positively; seven reported no influence. In general, the directors felt that the training workshops had better equipped staff members to deal with their tasks, had increased their professionalism, and had made them more sensitive and responsive to the people they were dealing with in the community. Perception of the purpose of the Consultation Service varied, and this influenced opinions about what program components were most important.

The longer an agency was involved with the Consultation Service, the more positive its overall response tended to be. Furthermore, the directors of the agencies that had been with the consultation program longest were the ones who urged that more of the newer grassroots organizations be drawn into the program.

The majority of the agencies conceived of the major Consultation Service functions as upgrading the quality of services through training workshops and facilitating community dialogues and the sharing of resources; these activities succeeded well enough to create good will and noticeable respect among the affiliated agencies, no small feat in the annals of mental health consultation in any context, and particularly in urban ghetto neighborhoods. The positive attitude of most of the Puerto Rican and black directors to a consultation program directed by white professionals supports the observation that competence is considered more important than racial or cultural background in the provision of mental health services in the ghetto.

The ultimate test of the effectiveness of mental health consultation—the change in the quality of services offered by consultee agencies and the reduced incidence of social and psychiatric disability—was not measurable in this study.

Positive Forgetting: The Noninterference of Items Intentionally Forgotten

Robert A. Bjork

Whatever else it may be, memory is partly a matter of discrimination. Any attempt to recall requires a judgment of suitability or appropriateness. There are a variety of operations that improve the discriminability of the item to be recalled and, hence, improve recall. Repetition, rehearsal, and mnemonics can all be thought of as such operations. The discriminative process underlying memory can also be improved by operating on the background out of which the item to be recalled must be selected. Reducing the number, similarity, or temporal proximity of presentation of other items in memory are all such operations.

This paper reports several studies based on a paradigm that provides new information as to how items to be recalled are stored, organized, and retrieved out of the noisy context of items not to be recalled. The paradigm involves an instruction to the subject that he can forget some or all of the items he has seen and has tried to remember, that he will no longer be responsible for those items.

Experiment I

The term "proactive interference" has come to label an empirical performance decrement and a theoretical mechanism (response competition produced by stimulus overlap) assumed by interference theory to explain the decrement. This double usage can be troublesome: an effect on performance labeled as proactive interference has been assumed to be thereby explained when, in fact, the effect may be due to factors other than associative interference.

This experiment was designed to clarify the extent to which proactive items produce performance decrements through associative interference and the extent to which they produce proactive interference through other mechanisms.

The subjects were 48 women students. Every subject was presented 64 lists of paired associates varying in length from one to eight pairs. A single test of one of the pairs followed each list: The paired associates were constructed from nonsense syllables as stimuli and common words as responses, and they were shown on slides. One-half of the pairs appeared on a green background, the other half on a yellow background. Test slides consisted of a stimulus member of a paired associate by itself on a white background.

The subjects were instructed that any time a list contained a color change, that is, any time the background changed from green to yellow or from yellow to green, they could forget the pairs shown on the first color. They were told that in such cases, the pair tested at the end of the list would be one of the pairs shown on the second color. The lists consisted of 0, 1, 2, or 3 pairs shown on a first color (color A), followed by 1, 2, 3, 4, or 5 pairs shown on a second color (color B). Thus, in one-fourth of the lists there was no color change, that is, no forget instruction. The different types of lists were presented in random order, so the subjects could never know when a

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list would or would not contain a forget instruction.

The paired associates were shown for 3 seconds each, and the test stimulus following each list stayed on until the subjects had responded. Each subject wrote her responses on cards, one response per card.

The principal results of Experiment I are three. (1) Color A ("forget") pairs appeared to provide no proactive interference whatsoever. Performance on a list was completely determined by the number of color B ("remember") pairs in the list and was completely independent of the number of color A pairs in the list. (2) Subjects frequently intruded respouses from color B pairs other than the one tested, but they almost never intruded responses from color B pairs. (3) The effects of serial position within a color B set were independent of the number of color A pairs in the list, and were completely typical of such probe experiments: there was little if any effect of primacy and there was a marked effect of recency.

In general, subjects seemed remarkably able to forget items when they were instructed to do so, at least in the sense that the forget-items did not interfere with performance on the items presented after the forget-instruction. In contrast, proactive items a subject is responsible for remembering do interfere with performance on subsequent items.

Experiment II

Experiment II was designed to provide control data against which to view the results of Experiment I. The procedure was the same as in Experiment I except that when a color change occurred in a list, it had no significance: subjects were equally likely to be tested on any pair in a list, independent of whether it was a color A or color B pair.

Experiment II serves as a control for Experiment I in two ways: Any proactive effects of color A pairs in Experiment II supply a measure of the extent to which the forget instruction in Experiment I facilitated performance, and if there are any effects of color change per se, they should be apparent in the results of Experiment II.

The subjects were 24 women students. Every subject was presented 64 lists of paired associates that varied in length from one to seven pairs. Each list was followed by a single test of one of the paired associates. The paired associates were identical to those used in Experiment I.

The lists consisted of 0, 1, 2, or 3 pairs presented on color A, followed by 1, 2, 3, or 4 pairs presented on color B. Thus, there were 16 different list-types. Forty trials were required to test every color B serial position, and 24 trials were required to test every color A serial position.

The lists that were followed by tests of color B pairs were identical to their counterparts in Experiment I. The lists that were followed by tests of color A pairs were constructed from the pairs used in the lists containing five color B pairs in Experiment I.

In order to insure that the subjects would be neither unaware nor distracted by color changes, effort was made to point out that most of the lists would contain a color change, although it also was emphasized that such color changes had no significance. All other details were the same as in Experiment I.

In contrast to the results in the comparable conditions of Experiment I, the color A pairs interfered systematically with performance on the color B pairs. There was a decrease

in performance on color B pairs as a function of the number of color A pairs in a list, and subjects frequently intruded responses from color A pairs when they were tested on color B pairs.

Experiment III

The results of Experiments I and II pose a challenge: to specify the processes by which subjects are able to forget items when instructed to do so.

There are at least three possible explanations of intentional forgetting. The most dramatic is the notion that subjects can actively erase or dump items from their short-term memory when instructed to do so. A second possibility is that items a subject is instructed to forget receive no further rehearsal or processing, are therefore lost from memory rapidly, and thus do not interfere with items the subject is to remember. A final possibility is the notion that subjects are able to accomplish a kind of set differentiation between the items they are to forget and the items they are to remember. At the time of recall, the subject searches only the remember-set and items in the "forgotten" set do not interfere, even though they may still exist in memory.

The active erasure, differential rehearsal, and differential grouping notions are not mutually exclusive. The differential rehearsal and differential grouping notions are somewhat related: they both assume that the subject can discriminate within his memory items to be remembered from items to be forgotten.

In Experiment I, the signal to forget occurred before the items to be remembered were presented. It is possible that the effectiveness of a forget instruction depends on its placement relative to the items to be forgotten. In Experiment III, forget instructions were presented either *before* or *after* the material to be remembered. The basic paired-associate probe procedure used in Experiments I and II was also used in Experiment III. Every list, however, contained two instructions to the subject, one in the middle of the list and one at the end of the list. The subjects were 36 women students.

The results of Experiment III were unambiguous. It mattered a great deal when the instruction to forget was presented. When the instruction to forget was presented before the pairs to be remembered, it was completely effective, when it was presented after the pairs to be remembered it was almost completely ineffective.

The Importance of Forgetting

When people voice complaints about their memory, they assume that the problem is one of insufficient retention of information. However, the problem may be partly a matter of insufficient or inefficient forgetting. If one views the human cognitive apparatus as an ongoing information-handling system, some mechanism to update the system, to keep the system current, is crucial. Computers handle the problem in a straightforward if somewhat drastic way. When new information is read into a location in memory, old information at the location is destroyed. Whatever the analogous human mechanism, it is certainly not so simple, nor so complete.

The positive function of any such forgetting mechanism is to prevent information no longer needed from interfering with the handling of current information. Consider the information-processing task faced by a short-order cook. He must process one by one (not strictly) a sequence of orders that have high interorder similarity. Once he is through with

"scramble two, crisp bacon, and an English," his later processing of similar but not identical orders can only suffer to the degree that he has not discarded "scramble two, crisp bacon, and an English."

The results reported here leave no doubt that subjects can use an instruction to forget to facilitate the handling of information that follows the instruction. But how?

A Theory of Intentional Forgetting

The basic assumptions of the theory proposed here could be phrased without difficulty in the language of interference theory or in the language of decay theory, but the assumptions propose processing mechanisms outside the basic constructs of either theory.

The theory asserts that subjects are able to take advantage of a forget instruction in two ways: they organize the items they are to remember in a grouping that functionally separates them from the items they are to forget, and they devote all rehearsal, mnemonic, and integrative activities following the forget instruction to the items they are to remember. The forget instruction can vary from completely effective to completely ineffective depending on the degree to which the experimental situation permits these selective grouping and rehearsal operations. Both processes assumed by the theory are necessary.

The fact that the "forgotten" items are not gone rules out the differential rehearsal assumption in the theory as a complete explanation of intentional forgetting. In order to provide a sufficient explanaton of intentional forgetting independent of the differential grouping notion, the differential rehearsal assumption must be coupled with the assumption that the forget items are lost from memory. It appears, instead, that the pairs to be remembered and the pairs to be forgotten are in two separate groupings, one the recipient of all rehearsal efforts following the forget instruction and, hence, quite available, the other left unattended and, hence, less available.

To some extent the differential grouping and differential rehearsal notions co-imply each other. In order to concentrate rehearsal efforts on the to-be-remembered pairs, those pairs must be defined as a set in some sense. Similarly, concentrating rehearsal and integrative efforts on certain pairs creates, to some degree, a distinct set out of those pairs.

The most important and least well-defined notion in the theory is the set differentiation idea. The basis on which the items to be remembered are separated from the items to be forgotten is unclear. There is not much doubt, however, that the abilities of humans to sort, group, and search selectively are considerable.

The theory asserts, in effect, that efficient forgetting of information no longer needed is as much a matter of reorganization as it is a matter of information loss. Items of information, no matter how similar and confusable, do not interfere with each other if they are organized into different groups.

Mental Health and the Law

Definitional Factors in Mental Incompetency

C. Allen Haney

The studies which have dealt with the legal determination of mental incompetency have focused primarily upon clinical attributes of the individual. Only recently has attention been given to the significance of societal reaction and to the theory that mental illness is as much an ascribed social status as it is a disease.

The idea that deviance is not an attribute of the individual's condition or his behavior but the application of rules and sanctions by others has been around for some time. But the application of the label is a significant event in that it can determine role expectations, self definitions, and possible loss of civil rights.

Something is known about the characteristics of the individual as they relate to the probability of being labeled mentally ill. Limited social power, marginality, and being a liability to one's family increase the chances of being so labeled. There is sizable literature which relates other demographic characteristics to the likelihood of being labeled as mentally ill. With regard to the legal determination or labeling of the mentally ill less work has been done. It has been found that the nature of the court hearing, the examination, and the legal routine do influence the adjudication process. The labeling model of mental illness or mental incompetency assumes that entrance into this category of persons is problematical, occurring only when one's group demands it, and that the group's tendency to apply this label is largely contingent upon nonmedical and extralegal factors. The present study deals specifically with these problems.

A series of hypotheses are advanced.

Social role of labeler—In what has become known as the labeling model of mental disorder the deviant is seen as an individual whose behavior has been defined by those about him as outside acceptable limits and for whom the tendency to deny the deviance has been suspended or not heeded. The crucial determiner of deviant careers is the degree to which the "suspect" individual plays the role assigned to him.

Some individuals are more effective labelers than others, either because of the expertise attributed to them or because of the relationship which they share with the one being labeled. Thus it is hypothesized that:

There is a relationship between the role of the person who first defines the alleged incompetent as mentally ill and the outcome of the adjudication process.

There is a relationship between the role of the person who first suggests the need for intervention by the court and the outcome of adjudication.

Consensus or pervasiveness of the label—Not only is role playing a function of the nature of the audience for which it is played, but it is a function of the extent to which the role offered is in conflict to alternative roles. Thus if some of the significant others in the life of the alleged incompetent do not share the definition of him as deviant, he will be less likely to play the role as fully.

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It was predicted that the extent to which the family was in agreement regarding the mental illness of the alleged incompetent and the number of individuals or agencies contacted regarding him, would be related to the outcome of the hearing. Specifically:

There should be a positive relationship between the degree of family consensus and a finding of incompetency.

There should be a positive relationship between the extent of discussions of the problem with other individuals and agencies and a finding of incompetency.

Behavioral factors—One of the key elements is the stereotype of mental disorder. This stereotype is seen as influencing both the labeler and the individual being labeled. Four hypotheses are drawn:

The nature and frequency of behavior of the alleged incompetent will be related to outcome; e.g., aggressive and suicidal behavior would be positively associated with a finding of incompetent.

The initial symptoms and the behavior which caused the most concern for the petitioner will be associated with the outcome.

Critical incidents or "last straws" will be more frequent and of a more threatening nature among those adjudicated incompetent than those not judged incompetent.

Involvement of law officers will be associated with a judgment of incompetent.

Four counties of a southern State were selected as representative of that State. In each county the court records were examined starting from October 1966, and working backward in time to identify consecutive competency cases which had ended in a judgment of competent. In no county did this process require going back more than 3 months. These cases were grouped in terms of week of occurrence, and an equal number of cases were randomly drawn from those cases judged incompetent in the same week.

The total sample consisted of 130 cases. For each case data were extracted from the court record and the family member who had signed the petition requesting the sanity hearing was interviewed. There were seven instances of refusal to be interviewed and 17 cases in which the subject could not be located.

Social role of labeler—It was predicted that the role of the person first identifying the alleged incompetent as mentally ill would be associated with final outcome.

In those instances where the petitioner was the first to impute mental illness there is a greater likelihood of a finding of competent. A judgment of incompetent is more likely when the label is first used by a mental health professional or a member of the alleged incompetent's family other than the petitioner.

For those judged competent, court action was more likely to have been suggested by the petitioner. For those declared incompetent, in a majority of the cases the need for court action was first suggested by a mental health professional.

Consensus or pervasiveness of the label—Respondents were asked if all the people involved were in favor of the proposed competency proceeding. These responses were not related to outcome since consensus was reported in approximately 95 percent of the cases in both outcome categories. An attempt was made to determine the level of consensus by asking if anyone opposed the incompetency proceedings. Direct or indirect action to block the legal proceedings occurred in only

four cases, and in only one of these four the alleged was declared incompetent.

The respondents were asked if they discussed the possibility of court action with anyone. It was found that those petitioners who were successful in having the alleged incompetent judged incompetent differed significantly from those who were unsuccessful. Nearly 90 percent of the former responded that they had discussed their decision with others of the family, while slightly more than 70 percent of the latter responded in this manner.

There is reason to believe that help-seeking could facilitate the development of consensus. The more contact the alleged incompetent has had with social and health agencies the greater the likelihood of his being adjudicated incompetent. There is indeed a clear relationship between the number of agencies contacted and outcome.

Behavioral factors—In order to determine the relationships between specific behaviors and outcomes, the respondents were asked five questions:

What was the first thing you noticed which indicated to you that _____ was ill?

What one thing about the way _____ was acting caused you the most distress or upset or concern?

What do you think people outside you and your family noticed about _____?

What aspect of _____'s behavior was the most difficult to deal with?

What was _____ behavior at the time of the critical incident?

The behaviors reported were quite limited in their range and quite similar in wording. Illustrative headings of the most frequent responses were as follows:

Involvement with a treatment agency
Harm to adult (threatened or actual)
Withdrawal or depression
Belligerence
Inexplicable behavior (unpredictable)
Irrational talk
Delusions and hallucinations
Excess drinking
Change of habit
Loss of interest (in events or circumstances)
Physical complaints
General nervousness

Those declared incompetent tended to have a greater percentage of physiologically based symptoms. With this exception, there were no significant differences in the reported behavior of the two groups. Thus, for the most part, our expectation was not confirmed.

It seemed reasonable to expect that the initial troublesome behavior and that which caused the most concern should be differentially associated with outcome. Again, no significant differences were found.

Taking a wider perspective on behavioral factors, the concept of critical incident was examined. The critical incident can be defined as the "last straw," a behavioral incident involving the deviant which contributes to the decision that the situation is no longer tolerable. Reasoning that these incidents tend to be more highly visible, have an element of crisis in them, and tend to center attention on the deviant, it is argued that they do much to crystallize the definition of the deviant as mentally ill. This was not the case, for although a significant relationship was found to exist between outcome and critical incident, the direction of this relationship was the opposite of that predicted, with a higher frequency of such incidents among those who escaped the judgment of incompetency.

Regarding critical incidents, one would reason that violence or aggression would occur most frequently in the group adjudicated incompetent. This did not prove to be the case, for 49 percent of the behaviors mentioned

as critical incidents in cases declared incompetent involved violence or aggression as compared to 42 percent of those judged competent—not a remarkable difference. This finding would tend to raise doubts regarding the effectiveness of the incompetency laws which are designed to protect society from the danger of the mentally ill.

It was predicted that if the behavior cited as the critical incident was of a potentially dangerous or threatening nature it would be more often associated with a judgment of incompetency. The data do not support this contention.

It was expected that if the behavior was severe enough to require the attention of law officers, the chances of a judgment of incompetency would be increased. Although involvement with the authorities was significantly related to outcome, the relationship was not in the expected direction. Of those cases where the legal authorities were not involved, the cases were roughly equally divided by outcome. Where legal authorities were involved, over 80 percent escaped the judgment of incompetency.

These findings are subject to interpretation from several perspectives. Within the conventional medical framework it could be argued that these findings are exactly what would be expected. The more disturbed the person is, the greater the likelihood of his being seen by a specialist, the family having agreement about his sickness, and advice being sought from a number of sources. The current findings are particularly subject to this interpretation since we did not have clinical evaluations of the subjects.

It was found that the number of agencies contacted in seeking help for the alleged incompetent was related to the outcome of the incompetency proceedings. It can be argued that contact with the help-source by the alleged incompetent reinforces the stereotype for both the alleged and the petitioner. The petitioner's suspicions about the deviant are reconfirmed and thereby denial is made less feasible. Secondly, contacting the help-source, with its illness orientation, may drive home to the alleged incompetent that he is indeed mentally ill and make it much more difficult for him to think of himself in any other way.

When one considers the evidence that help sources seldom, if ever, turn away a patient and are prone to find pathology, the seeking of help from a mental health agency or even a minister is stacking the cards in favor of a self-definition of mental illness.

If the outcome of the incompetency proceeding reflects a rational process dependent upon the pathology of the individual, clear differences should appear with respect to a number of behavioral factors. This was not the case in the present research. These findings suggest that a finding of mental incompetency is dependent to a significant degree upon factors other than the pathology of the individual.

Recent Cases

In re Harmon, U.S. Court of Appeals for the First Circuit, 38 LW 2619, May 6, 1970

Defendant was charged with transporting a stolen aircraft across international borders. The complaint was dismissed when examination raised doubts about his mental ability to stand trial. The government later renewed the complaint, and the defendant was sent to the Medical Center for Federal Prisoners in Springfield, Missouri. The Center eventually discharged him as improved. The district court then arranged for further mental examinations and, after a

hearing, concluded that defendant still was not competent to stand trial. The court therefore returned the defendant to the Medical Center for further psychiatric observation and treatment. Defendant asked the Court of Appeals to vacate the order of the district court committing him to the custody of the Attorney General, and to remand for a trial on the offense charged.

The Court of Appeals gave a judgment for the defendant. It did not set aside the determination of the lower court concerning competency to stand trial because there was evidence calling into question the defendant's ability to consult with his lawyer with a reasonable understanding of the proceedings under the stress of trial. Nevertheless, the court noted, it was upsetting the result of the court below because it was disturbed by the defendant's lengthy confinement—approaching a year—without the safeguards of a trial on the offense charged or formal commitment proceedings addressed to defendant's ability to function in society. Such confinement, the court said, not only "erodes the values protected by the right to a speedy trial, but . . . [is] of questionable clinical value." The court decided that defendant's competency to stand trial be redetermined in the near future, and suggested the following guidelines for the district court: (1) when a court appoints a psychiatrist under the Federal statute pertaining to insane criminals, the psychiatrist should consider himself an officer of the court, not responsible to prosecution or defense; (2) the expert appointed should have a substantial opportunity to observe the accused, and should, prior to the hearing, file with the court a written report summarizing his observations and indicating whether the accused is competent: (3) the more often trial is postponed, the more compelling should be the evidence justifying delay, and the more meticulous the procedural safeguards; and (4) if the accused is committed to the custody of the Attorney General, the district court should require frequent reports at stated intervals on the accused's mental condition.

Buchanan v. Batcheldor, U.S. District Court for the Northern District of Texas, April 30, 1970

Plaintiff Buchanan, a confessed homosexual, was arrested and charged under Texas law for acts of sodomy in a public place. He asked for a declaratory judgment on the constitutionality of the law in question. A married couple, alleging that Buchanan did not fairly and adequately protect the interest of married persons who fear future prosecution for the commission of private acts described as sodomy, were granted leave to intervene. Likewise, the court countenanced another intervenor, who claimed Buchanan did not protect the interests of homosexuals who do not commit acts of sodomy in public places but fear future prosecution because of acts of sodomy committed in private.

The court found the act void on the face for unconstitutional overbreadth insofar as it reached the private, consensual acts of married couples, and enjoined future enforcement of the Act. The Act, which reads "whoever," made no distinction whether acts it described as sodomy were committed in public or in private, whether they were committed homosexually or heterosexually, or whether by married or unmarried persons. Therefore, the court found, the Act did apply to private consensual acts between married persons and acts between homosexuals. And while the defense pointed out that married couples were not in practice prose-

cuted, the court said that the failure of the State to prosecute, so long as the law is on the books, does not answer an allegation of fear of prosecution.

Dalton v. State, 308 N.Y.S. 2d441, Supreme Court of New York, Appellate Division, March 11, 1970

The decedent had been hospitalized in State institutions for mental disturbances on four separate occasions from 1955 to 1964. At the time of this fourth hospitalization, after having been in the hospital a month, the decedent was permitted to spend her day in an open ward and walked out of the hospital and apparently committed suicide by jumping off a ferry boat. A suit for wrongful death against the State (for the hospital) was instituted by the decedent's estate. The trial court found that the decedent's history on prior admissions was such as to indicate suicidal tendencies, and found the State negligent in failing to provide adequate supervision to prevent her escape and suicide. The State appealed from this judgment.

The Appellate Division reversed, and dismissed the claim. The dispositive issue, it said, was whether or not the record contained evidence to support the conclusion that the State had notice that decedent was in any danger of harming herself and thereby requiring retentive supervision. After studying the hospital records in evidence, it found that the conclusion of the trial court could not be supported. The court relied on an entry in the hospital records made by a doctor 6 days before the patient's death. In this entry he noted that the patient appeared cheerful, denied feelings of depression, and showed no signs of overt psychotic trends, and stated that medication had been decreased, the patient was responding well to the smaller doses, and the patient would be considered for home visits in the near future. The hospital records, the court said, "show no marked suicidal tendencies and do not constitute sufficient evidence to support the finding that as of the decedent's last admission . . . [she] had definite or probable suicidal tendencies. The testimony . . . is devoid of any references to actions or statements . . . [by] the decedent which would infer suicidal tendencies. . . . In the absence of a showing of suicidal tendencies on the part of the decedent, the State cannot be liable for a failure to provide adequate supervision." The court rested its decision not on a question of informed medical judgment, therefore, but instead on a fact finding as to suicidal tendencies.

State of Illinois v. Hammond, Illinois Supreme Court, March 1970

Defendant, a 13-year-old juvenile, was charged with murder in an adult criminal proceeding. His counsel contended that the boy lacked the mental capacity to stand trial and the requisite understanding of the charges.

The court found the defendant to be competent. Among the factors considered in the determination were the following: the defendant answered his counsel's questions in a "rational and orderly manner;" although evidence indicated defendant's school record was poor, his grades were fair and he did not disrupt classes; he worked a newspaper route; he played little-league baseball; and no manifestations of emotional or psychiatric disturbances were noted in his past history. Under these circumstances, the court said, defendant had the capacity to stand trial, as he was able to comprehend the charges against him and was mentally competent.

Note: The material on recent cases is prepared by the Legislative Services Branch, NIMH.

Protocol on Psychotropic Substances

A conference on the "Protocol on Psychotropic Substances" will be held in early 1971 to consider adoption of an international treaty. The protocol was prepared by the Commission on Narcotic Drugs and submitted last January to the United Nations Economic and Social Council. The Commission was made up of 24 members: Brazil, Canada, Dominican Republic, Federal Republic of Germany, France, Ghana, Hungary, India, Iran, Jamaica, Japan, Lebanon, Mexico, Pakistan, Peru, Sweden, Switzerland, Togo, Turkey, Union of Soviet Socialist Republics, United Arab Republic, United Kingdom, United States of America, and Yugoslavia. There also were observers from several other countries as well as representatives from the World Health Organization, Universal Postal Union, International Narcotics Control Board, Permanent Anti-Narcotics Bureau of the League of Arab States, and observers from the International Council of Women, Friends World Committee for Consultation, International Criminal Police Organization, International Federation of Women Lawyers, and International Council on Alcohol and Addictions.

The Protocol provides for international "controls" for a large number of psychotropic substances—hallucinogens, amphetamines, barbiturates, tranquilizers, etc. It also provides that the decision on which substances should be brought under control by the treaty will be determined by the World Health Organization in terms of medical and scientific considerations. The WHO will make recommendations to the Commission on Narcotic Drugs, which will also consider economic, social, legal, administrative, and other factors.

The full text of the protocol appeared in the *Bulletin on Narcotics,* Vol. 13, No. 3, 1970, which may be obtained from the United Nations Sales Section, New York, N.Y. (or Geneva) for $1.00.

1970 APA Achievement Awards

The 1970 Achievement Awards presented annually by the Hospital & Community Psychiatry Service of the American Psychiatric Association were announced at the 22nd Institute on Hospital & Community Psychiatry.

Help for Mentally Handicapped Children—The Gold Award went to the Children's Psychiatric Research Institute of London, Ontario for its comprehensive regional children's center, which gives free services in southwestern Ontario. Opened in 1960 as a psychiatric hospital for retarded children, it was later expanded to include services for other mentally handicapped children and adolescents. It is affiliated with the University of Western Ontario as a teaching hospital.

Preventive Action in the Battle with Drugs—Project DARE (Drug Abuse and Education) in Los Angeles won the Silver Award. Most of the participants are teenagers who do not use drugs. Through films, exhibits, literature, discussions, they try to provide information about drug abuse as well as to reduce adult anxieties about psychedelic art, rock music, long hair, etc.

A Community Mental Health Consortium—The Bronze Award was given to the Westside Community Mental Health Center, Inc., a consortium of 16 public and private agencies that provide comprehensive mental health care to all residents in the Westside area of San Francisco.

Detailed descriptions of the three programs are given in *Hospital & Community Psychiatry,* October 1970.

Institute in Suicidology: West

A Western Institute in Suicidology is scheduled for January 23 through January 27, 1971, in Los Angeles. This second Institute, sponsored by the Suicide Prevention Center of Los Angeles, in collaboration with the Center for Studies of Suicide Prevention, National Institute of Mental Health, will provide a comprehensive training experience for professionals and laymen who are interested in, or working in, the field of suicide studies or prevention. An interdisciplinary faculty will include outstanding leaders in the field from across the country.

The curriculum will cover such areas as Prediction of Lethality, Epidemiology, Current Research, Legal Aspects, Other Life-Threatening Behaviors, Special Risk Populations, Suicide Models, Community Involvement, plus special-interest discussion groups.

The registration fee is $20.00. There will be limited scholarship assistance available. Further information may be obtained from Mr. Sam M. Heiling, M.S.W., Director of Training Suicide Prevention Center, 2521 West Pico Boulevard, Los Angeles, California 90006.

Directory of Drug Information Groups

A *Directory of Drug Information Groups* has been published by the Student Association for the Study of Hallucinogens. It is intended to fulfill a need for a central source of pertinent data on drug education, counseling, and treatment programs, and therefore to serve as a resource guide to organizations concerned with drugs and drug information. The information was supplied by the groups themselves. Information about the Directory may be obtained from STASH Press, 638 Pleasant St., Beloit, Wis. 53511.

Publications on Social Work Administration

Social Work Administration: A Resource Book, edited by Harry A. Schatz, is a selection of readings—classical and contemporary—on concepts and theories of administration applicable to social work. The price is $4.00.

A Casebook in Social Work Administration, also edited by Harry A. Schatz, is a selection of 25 cases rooted in the living experience of administrative situations within the broad topics of organizational structure, changes, and reorganizational administrator and staff relations; administrator and board relations; labor relations; client relations; budget and finance; community and interagency relations; environmental changes and agency readjustments, and decision making. The book should be especially useful to administrators of community mental health centers. Both may be ordered from the Council on Social Work Education, 345 East 46th Street, New York, N.Y. 10017.

One Million Children

The report of the Canadian Commission on Emotional and Learning Disorders in Children, "One Million Children," is now available. The report estimates that some 12 percent of children and youth—over one million—need attention because of emotional and learning disorders, and makes recommendations for meeting this need. It may be ordered from the Commission on Emotional and Learning Disorders in Children, 165 Bloor St., W., Suite 302, Toronto 5, Ont. for $8.00 (in Canada).

* U.S. GOVERNMENT PRINTING OFFICE: 1970 O—435-723/5

recent nimh publications

Single copies of these publications may be obtained from the Office of Communications, National Institute of Mental Health, LL02, 5454 Wisconsin Ave., Chevy Chase, Maryland 20015. A complete list of all publications available from the NIMH may also be obtained from the Office of Communications. If a price is given, the publication may be ordered in quantity from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Enclose a check or money order payable to the Superintendent of Documents.

Crime and Delinquency Abstracts and Current Projects—An International Bibliography. Vol. 6, 1969.

Careers in Psychiatry. This brochure describes the U.S. Public Health Service's Mental Health Career Development Program.

Biological Rhythms in Psychiatry and Medicine. This 191-page monograph reviews research on biological rhythms. Written by Gay Gaer Luce for the Program Analysis and Evaluation Branch, NIMH. Public Health Service Publication No. 2088. $1.75.

The Voluntary Agency and Community Mental Health Services. This 27-page pamphlet, designed primarily for the citizen concerned with the organization and delivery of community mental health services, describes the activities of several "voluntary agencies." Public Health Service Publication No. 2090. 20¢.

Mental Health Research Grant Awards. Fiscal Year 1968. (Public Health Service Publication No. 2105. 40¢)

Mental Health Research Grant Awards. Fiscal Year 1969. (Public Health Service Publication No. 2106. 40¢)

These two publications provide information about the research grants awarded by the NIMH.

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